Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
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INSPECTION REPORT SUMMARY #1

Robert Ewing, Administrator
Evergreen Castro Valley Healthcare Center
20259 Lake Chabot Road
Castro Valley, CA 94546

Number of beds: 91

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Alameda County team conducted a survey of Evergreen Castro Valley Healthcare Center, located in Castro Valley, on April 3, 2001.The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

Care Issues

1. The resident in room 19A had an order and care plan stating that she was to wear mitts at all times to prevent her from scratching herself. The team noted that her mitts were not in place and were nowhere in sight. The resident was furiously scratching her arms and they were bleeding.

2. Two residents, room 7A and room 20B, had no fresh water or no water at all. Many water pitchers were out of reach of the resident.The medication administration records and the treatment records do not always have a signature for the nurses' initials for administration.

3. The nurses' notes lacked detailed descriptions for injuries, and summaries were repetitive.

4. The annual history and physical forms for the residents lack an interval history and in some cases lack proper documentation of a physical examination by the physician.

5. The medication administration records and the treatment records do not always

have a signature for the nurses' initials for administration.

Environmental

6. There were multiple screens on residents windows and sliding doors which did not slide smoothly. There were many screens that had holes, were bent, or were off-track. This would allow flies entry into the facility when the doors are opened.

7. There were drapes in various areas that were falling down.

8. There was an odor of urine in the facility when the team entered.

9. There were soiled linen carts which did not have the lids on properly, allowing the odor to emanate throughout the facility.

10. There were some handrails in the hallways that were in need of sanding and refinishing to prevent injury to the fragile skin of the residents.

11. The recreation room, although empty and early in the morning was very messy and the floor was dirty.

12. Hallways were cluttered with wheelchairs and carts and did not allow a clear pathway for the residents should an emergency arise.

Administrative

13. When the team entered the facility and for the first two hours many of the staff were not wearing identifying name badges.

14. Residents' personal inventory lists were not being kept up to date.

Staffing

No issues were detected

Fire

a. Cross corridor doors in 26, 20, 28 did not close properly when tested. Doors are not smoke tight and do not provide one barrier. Smoke barrier doors shall be one hour, labeled and with positive latching.

b. Flammable Liquid Cabinets shall be provided for combustibles in the maintenance shop and for the generator back up fuel sources.

c. Helium tank shall be secured by chain or strap at top and bottom of cylinder, in a rack or against a wall. Combustibles shall not be stored in the same location as this cylinder.

d. The elevator machine room shall not be utilized for storage of combustible materials.

e. Parking garage area storage shall be maintained in a neat and orderly fashion.

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INSPECTION REPORT SUMMARY #2

Jean Jardine, Administrator
Empress Convalescent Hospital
1299 S. Bascom Avenue
San Jose, CA 95128

Number of beds: 67

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Empress Convalescent Hospital, located in San Jose, on April 4, 2001. The team noted the following issues which were discussed during the exit meeting:

Care Issues

1. The registry sign-in book was being used inconsistently.

2. Review of the medical records revealed that staff is failing to properly initial treatments on the treatment sheets, indicating that the treatments are not being done as ordered.

3. The annual history and physicals are not up to date and lack physical findings and an interval history.

4. Many residents lacked name bands.

5. Many residents' nails were dirty and ragged.

6. Mouth care for many residents was lacking, dentures were left dry in denture cups while residents were trying to eat breakfast, and water pitchers were not within easy reach for bed or chair-ridden residents.

Environmental

7. There was a moderate odor of urine noted when the team entered the facility.

8. There was a coin operated candy dispenser by the lobby door, allowing unsupervised access by residents on sugar restricted diets.

9. Multiple windows and patio doors have bent, torn and off-track screens. Some are missing screens and one was missing a screen and the window had been left open.

10. There was a garden hose spread across the patio walkway, causing a hazardous condition for residents with walkers.

11. There were several loose bricks lying on the lawn, which is a hazard to residents, staff, and visitors who may walk by.

12. The weatherstripping on the diningroom exterior door was badly worn.

13. There were snack and soda vending machines located in the staff lounge, but the lounge door was propped open, allowing for unsupervised access to the machines by residents on special diets.

14. The housekeeping storage closet was found unlocked and unattended, and contained cleaning chemicals.

15. The handle of the freezer in the kitchen was broken.

16. There was a small amount of water damage under the kitchen sink.

17. There were used gloves on the floor of the shower room by room 113. There also was a large growth of mildew in the shower stall of the same shower room.

18. The shower room occupancy room signs are not being appropriately used by the staff.

19. There was a buildup of mildew beginning in the shower room by the social services room. There was also dirty linen left on the floor.

20. There was food being stored in the medicine refrigerator next to medication.

Administrative

21. The personnel files reviewed lacked documentation of reference checks.

22. The personnel files of two staff, one CNA and one LVN, lacked up to date license/certification. They also lacked documentation that any attempt was being made to confirm proper licensing.

Staffing

Below minimum daily requirements.

Fire

Unavailable.

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INSPECTION REPORT SUMMARY #3

Linda Trevino, Administrator
Katherine Healthcare Center
315 Alameda Street
Salinas, CA 93901

Number of beds: 51

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Monterey County team conducted a survey of Katherine Healthcare Center, located in Salinas, on April 24, 2001. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

Care Issues

1. Shower rooms lack occupancy signs. While checking the shower, one the team members knocked, received no reply and walked in on a patient being showered without the curtain drawn.

2. The team was concerned about the resident's safety near the hot radiators located in the hallways and various rooms.

Environmental

3. There were screens on several windows which were badly bent. This would allow flies entry into the facility when the windows are opened.

4. There was a damaged handrail next to room 15.

5. There were uneven concrete squares on the resident's patio, which could pose a hazard to resident's walking in the area, even if they are supervised.

6. There was a moderate odor of urine in the hallways when the team first arrived and varied in intensity at different times throughout our visit.

7. In the oxygen closet there were multiple large oxygen tanks loosely chained with only one chain, and a small tank on a cart which had been stacked on some empty water bottles.

8. The beauty shop was unlocked and unattended. There was germicidal liquids in one open cupboard.

9. The patients beds are old and don't all raise and lower properly, and the mattresses are also quite old and lumpy.

10. In the kitchen there was unlabeled/dated foods in both the freezer and the refrigerator. There was a roast in one refrigerator that was not properly covered. In the ice cream freezer there were containers of ice cream left open, uncovered and unlabeled/dated.

11. The double doors leading outside lack proper fire exit handles and there is no weather stripping between the doors to prevent flies from entering the facility.

12. There is a cracked and broken tile behind the door in the shower room on the second floor.

13. There is a concrete stairway leading to a lower level from the parking lot which leads to the maintenance room and laundry. There is no gate to prevent a resident, who may wander out to this area, from falling down the stairs. All the entrances on the lower level of this area were open and there were chemicals next to one of the doors. These could be hazardous to residents.

14. There was a ladder left unattended against the wall in the activity room.

Administrative

15. Patient's personal property inventory sheets are not all up to date, and patients property such as televisions are not indelibly marked to prevent theft.

Staffing

No problems were detected

Fire

Unavailable.

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INSPECTION REPORT SUMMARY #4

John Pritchard, Administrator
Arden Rehabilitation & Health Care Center
3400 Alta Arden Expressway
Sacramento, CA 95825

Number of beds: 170

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Sacramento County team conducted a survey of Arden Rehabilitation & Health Care Center, located in Sacramento, on April 26, 2001. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

Care Issues

1. The treatment cart on the west station was found to be unlocked, and contained medicated ointments in an unsecured drawer.

2. Patient call lights were not being answered in a timely manner, as observed by the team. Two instances were noted in which it took in excess of ten minutes for the non-emergency call to be answered.

3. A review of the medical records by the team physician noted that laboratory work is not always being done when needed, i.e., residents on Lasix for prolonged periods should have potassium levels checked.

4. It was also noted that some of the physicians are using the acute hospital physical as the SNF initial physical. At the time of the next annual physical the doctor is documenting "unchanged." If the physical exam was done as required the findings must be noted and not documented as "unchanged," even if they are essentially the same.

5. When passing room 404 it was noted that the CNA was providing morning care to the patient with the door open and no privacy curtains drawn.

6. There were no occupancy designations on the shower room doors which allow for easy violation of the residents right to privacy if someone walks into the room. It was also noted that privacy curtains were not being used in the shower rooms.

7. Some patients complained that it takes too long for food to be served off the carts to patients eating in the dining room.

Environmental

8. There were screens on several sliding doors which did not slide smoothly. A number of screens had holes in them, were bent, or were off-track. This would allow flies entry into the facility when the doors are opened.

9. As discussed, there were snack and soda vending machines located in the patient dining room which would allow unsupervised access to the machines by patients who may be on special diets, and could be a hazard to the health and safety of those patients.

10. There was one loose handrail in the hallway located across from the front dining room.

11. There was an odor of urine in the facility when the team entered.

12. There were soiled linen carts which did not have the lids on properly, allowing the odor to emanate throughout the facility.

13. On the north side of the building the roof is missing some tiles. There are also some roof capping tiles missing.

14. There appears to be a water drainage problem as noted by the placement of sandbags in front of some patient's patio exit doors. The pipes leading from the down-spouts were resting on the concrete rather than draining into an appropriate drainage area.

15. The outside smoking area for the staff was heavily littered.

16. The stucco near the roof of the south corner near the maintenance room is damaged in a large area.

17. Oxygen tanks in both the east and west station closets were not properly secured.

18. There were leaking pipes behind two of the washing machines.

19. There were items that were left undated in the kitchen refrigerator and freezer.The door to room 509 has a large portion that is damaged and splintered.

Administrative

20. Personnel files were reviewed and approximately half lacked up to date expiration dates for the licensed/certified staff.

Staffing

21. There were complaints about a lack of sufficient staffing at night.

Fire

Unavailable

ARDEN REHABILITATION
3400 Alta Arden Expressway, Sacramento, CA 95825
916-481-5500

April 19, 2002

Special Agent Diana Boutin
2025 Gateway Plaza, Suite 474
San Jose, CA 95110

RE: Arden Rehabilitation and Health Care Center

Dear Ms. Boutin:

Thank you for your letter of March 28th, summarizing the findings of your recent visit to our facility.

Your positive comments and favorable findings are evidence that our efforts to provide superior quality care and comply with all regulatory requirements have been fruitful.

Although you indicated that it is not a requirement, we are enclosing a response to those issues, which you have identified. Certainly, if any additional information would be helpful, we would be pleased to provide it.

Sincerely.

Robert Bowersox
Administrator

Cc: Steve Keh

	Recommendation	Comment	Responsible Party	Completion Date
1	There were screens on several sliding doors, which did not slide smoothly. A number of screens had holes in them, were bent, or were off-track. This could allow flies entry into the Facility when the doors are opened.	*Screen doors were inspected and replaced after the March 2001 inspection. * The screens are inspected and replaced as needed. .	Maintenance	4/10/01
2	Snack and soda vending machines were noted to be located in the patient dining room, which would allow unsupervised access to the machines, by patients who may be on special diets.	*Vending machines were moved to a secure area in the employee lounge	Maintenance	4/10/01
3	There was one loose handrail in the hallway located across from the front dinning room.	*The loose handrail was fixed after the March 2001 inspection. Handrails are regularly checked by the maintenance Department.	Maintenance	4/10/01
4	There was an odor of urine in the facility when the team entered.	*The odor has been traced to a specific resident who empties her catheter bag onto the floor and bedding. The mattress has been replaced and room thoroughly disinfected. This patient is being closely monitored to assure that odors are kept under control. *Housekeeping regularly checks and cleans the hallway and rooms to identify and eliminate the source of any urine odors. *Success in eliminating this odor is evidenced by favorable comments of family and residents.	Housekeeping	Ongoing
5	Some soiled linen carts were observed that did not have the lids on properly, allowing an odor to emanate throughout the facility.	* Continuous in-service is presented to staff regarding keeping the soiled linen carts closed at all times. *Housekeeping regularly checks and empties the soiled linen barrel to eliminate overflowing of soiled linen.	DSD	Ongoing
6	The treatment cart on the west station was found to be unlocked, and contained medicated ointments in an unsecured drawer.	*The treatment nurse and Licensed Staff were in-serviced concerning this matter, and will be once again in-serviced to stress the importance of keeping the carts locked at all times.	Director of Nursing	4/10/02
7	The faucets in the west station utility were leaking.	* These were checked and corrected by the Maintenance Department.	Maintenance	4/8/02
8	Patient call lights were not being answered in a timely manner, as observed by the team. Two instances were noted in which it took in excess of ten minutes for the non-emergency call to be answered.	* Licensed Staff and Certified Nursing Assistants have been in-serviced regarding the necessity of answering call lights in a timely manner.	DSD Director of Nursing	4/11/02

	Recommendation	Comment	Responsible Party	Completion Date
9	There were no occupancy designations on the shower room doors, which could result in violation of a resident right to privacy. It was also noted that privacy curtains were not being used in shower rooms.	*Signs designating the occupancy of shower rooms have been ordered and will be installed on all shower room doors, to prevent un-authorized entry during a resident shower. * Staff has been in-serviced concerning means to preserve resident privacy.	Maintenance DSD	4/10/02
10	A review of the medical records by the team physician noted that laboratory work is not always being done when needed, I.e., residents on Lasix for prolonged periods should have potassium levels checked	* This matter has been referred to and discussed with our Medical Director. Physicians have been asked to be diligent in their orders for laboratory work when indicated.	Director of Nursing	7/1/2002
11	It was noted that some of the physicians are using the acute hospital physical as the SNF initial physical. At the time of the next annual physical the doctor is documenting "unchanged". When a physical exam is completed as required, the findings must be noted and not documented as "unchanged", even if they are essentially the same	* This matter has been referred to and discussed with our Medical Director. Physicians have been advised of the BMFEA recommendation.	Director of Nursing Medical Director	7/1/2002
12	On the north side of the building the roof is missing some tiles. There is also some roof capping tiles missing.	* Missing tiles were replaced immediately following the March 2001 inspection	Maintenance	4/10/01
13	There appears to be a water drainage problem as noted by the placement of sandbags in front of some patient's patio exit doors. The pipes leading from the down-spouts were resting on the concrete rather than draining into an appropriate drainage area	* Drainage problems have been resolved; drains opened, and downspouts relocated to empty run-off water to appropriate areas.	Maintenance	4/10/01
14	The outside smoking area for the staff was heavily littered	* Housekeeping inspects the employee patio daily	Housekeeping	Ongoing
15	The stucco near the roof of the south corner near the maintenance room is damaged in a large area.	* Stucco has been repaired.	Maintenance	4/10/02
16	Oxygen tanks in both the east and west station closets were not properly secured.	* Central Supply checks the oxygen room daily. * Licensed Staff has been in-serviced about the safety hazards of improperly secured oxygen tanks.	Central Supply Director of Nursing	Ongoing 4/10/02
17	There were leaking pipes behind two of the washing machines	* Pipes have been inspected and are not leaking, an overflow vent, which allows excess suds to vent from machine is expected to be the source of the observation.	Maintenance	4/10/02

Recommendation	Comment	Responsible Party	Completion Date
18 There were items that were left undated in the kitchen refrigerator and freezer.	* All food items in the kitchens are maintained with dates. *Dietary Supervisor ensures compliance.	Dietary	Ongoing
19 The door to room 509 has a large portion that is damaged and splintered	* A new door has been installed in room 509.	Maintenance	4/10/02
20 When passing room 404 it was noted that the CNA was providing morning care to the patient with the door open and no privacy curtains drawn.	* Ongoing in-service is conducted to the Staff regarding resident privacy and dignity,	DSD Director of Nursing	Ongoing 4/10/02
21 Some patients complained that it takes too long for the food to be served from the carts to patients eating in the dining room.	* Ongoing in-service will be conducted to the staff regarding serving meals on a timely manner. Charge Nurses to ensure compliances *Dinning room cart schedules have been reviewed and evaluated to allow sufficient time for staff to prepare for their arrival.	DSD Director of Nursing	Ongoing 4/10/2002
22 There were complaints about the sufficient staffing at night.	* The facility has engaged a full-time staffing coordinator with the responsibility for securing adequate staff to meet the average 3.2 staffing hours per patient day.	Staff Coordinator	Ongoing
23 Personnel files were reviewed and approximately half lacked up to date expiration for the licensed and Certified Staff.	* Licensed Staff and Nursing Assistant Certification are updated by the Director of Staff Development to ensure that employees have current License or Certificate.	DSD	Ongoing

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INSPECTION REPORT SUMMARY #5

Dawn Norrington, Administrator
Valle Verde Health Facility
900 Calle de los Amigos
Santa Barbara, CA 93105

Number of beds: 80

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise revisit of Valle Verde Health Facility located in Santa Barbara, on May 2, 2001. The areas of concern previously noted by the team, and discussed with the facility staff during our exit meeting appeared to have been eliminated. The facility was odor-free and very clean. The staff was friendly and very cooperative with the survey.

It was very rewarding to find that the facility took the suggestions of the team and corrected all areas that we had mentioned. The facility continues to make improvements on a daily basis as evidenced by the documentation reviewed and the observations of the team.

Care Issues

No problems were detected

Environmental

No problems were detected

Administrative

No problems were detected

Staffing

No problems were detected

Fire

Not applicable

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INSPECTION REPORT SUMMARY #6

Milton Wheeler, Administrator
Subacute/Saratoga
13425 Sousa Lane
Saratoga, CA 95070

Number of beds: 36

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Santa Clara County team conducted a survey of Subacute Saratoga, located in Saratoga, on May 9, 2001. The following areas of concern were noted by the team and discussed with the facility administrative staff during our exit meeting, and some items noted after review of the team notes:

Care Issues

1. As discussed with the Director of Nurses, staff caring for the resident in room 16 was not following the facility's procedure and policy regarding isolation, although the charge nurse said she was on contact isolation.

2. The facility has been without a medical director for adult patients for several months.

Environmental

3. There were screens on several sliding doors which did not close properly. There were several sliding doors which were noted to be open with the screen also open. This would allow flies entry into the facility. Some sliding door screens were also noted to be torn.

4. The shower room is missing a tile. What the team thought was mildew in the corners, Mr. Wheeler said is glue.

5. The facility is badly in need of painting in some areas, particularly the resident's room doors.

6. There was a leaking faucet in the patio area. Next to the faucet is an air-conditioning unit which is dripping constantly. There is a buildup of slime beneath both the faucet and the air-conditioning unit.

7. The outside storage room for the refrigerated oxygen tanks was left unlocked.

8. The area partition directly above the air-conditioning unit in the laundry room is missing, allowing flying insects into the facility.

9. There was an uncovered trash container by the building outside.

10. There were small amounts of caustic chemicals left in plastic containers outside.

11. The laundry room storage closet contains chemical substances and was left unlocked.

12. There was a leaking washing machine in the laundry room. The leaking water was being dammed in by wet towels.

13. The housekeeping room located by the laundry room contained chemical substances and was unsecured.

14. There is an area of coving near the refrigerators in the kitchen which is missing. There is also an area of coving in room 15 which is missing.

15. The utility room was generally a mess. The electrical cords attached to various machines were not properly secured and out of the way.

16. The housekeeping closet which housed the floor polisher and chemical substances was found to be unlocked.

17. Nut and candy dispensers were located near the front door. This could be a hazard by supplying restricted diet patients to items that are not appropriate and potentially harmful to their diet. There were also snack and soda machines which are considered a hazard by the team. These allow unsupervised access to the machines by persons on restricted diets.

18. There were gaps noted in the doors leading outside, along with gaps around the air-conditioning units. This would allow insects into the facility.

19. There were multiple hazards outside in the patio area which were discussed in detail with the staff at exit, and shown to the staff during the survey. These include uneven concrete, water hoses in pathways, sudden drops from the patio to the grass, holes rotted in the wood of the patio and a slat of the patio which was not nailed down.

20. The housekeeping in the facility was found to be poor. The rooms were dusty and generally messy, and many of the floor areas were dirty. The utility room was particularly messy with electrical cords and equipment scattered around.

Administrative

21. The resident's rights and various other policies which were posted in the lobby glass case were secured on top of each other, making parts of the rights impossible for residents or their family to read it.

Staffing

No issues were detected**.**

Fire

a. Keep laundry room door closed when unattended.

b. Provide an 18" clearance from the ceiling at all times in rooms five and six.

c. Flame regardant all items combustible in room six.

d. Remove air conditioner causing a trip hazard and wires/lines going through door. Sliding door or screen must remain closed at all times

e. Door must be able to be closed and latched at all times in rooms 3 - 6,14, 18, and 19.

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INSPECTION REPORT SUMMARY #7

Matt Neal, Administrator
Eskaton Manzanita Manor
5318 Manzanita Avenue
Carmichael, CA 95608

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Eskaton Manzanita Manor, located in Carmichael, on May 1, 2001. The following are the issues noted by the team and discussed in the exit conference held with the administrative staff:

Care Issues

1. The medication administration sheets lacked signatures for many of the nurses' initials.

2. The residents' annual history and physical's were not always done in a timely manner, lacked interval history, and lacked physical findings of many systems.

3. The MDS forms and resident care plans were inconsistent and did not truly mirror the current condition of the resident.

4. Nurses notes lacked detailed descriptions of injuries and bruising, such as proper measurement, and lacked follow up documentation in many instances.

Environmental

5. There were several bent window screens near the back parking lot area of the building and on some of the lower front windows.

6. There was a water hose left across the sidewalk pathway used by residents and visitors, posing a potential hazard for falling.

7. There was a faint to moderate odor of urine in the facility hallways when the team first entered. This disappeared after a couple of hours.

8. There were wheelchairs and carts on both sides of the hallways blocking a clear path to exit which would be a hazard to residents in an emergency.

9. There was a food cart and two wheelchairs blocking an emergency exit.

10. There was a minor amount of condensation on one of the refrigerators indicating that the gasket is worn and needs replacing.

11. There was food in the refrigerator which was not properly covered.

12. There were no occupancy signs on shower room doors and staff was noted to be entering the shower rooms without knocking, which would violate residents privacy.

13. The lids to the soiled linen carts were not closed properly, causing an offensive odor to emanate through the hallways.

14. There was a buildup of mildew in the shower stall of shower room 800.

15. There was an extension cord being used under the sink in room 503.

16. There was cabling hanging on the wall in room 404 which could be a hazard to some residents.

17. Housekeeping, in many of the rooms, was poor with trash under the beds.

Administrative

18. The RN license for [redacted] B. expired on 2/28/01 and there was no updated one in her personnel file.

19. The resident's personal inventory records were not up to date.

Staffing

No problems were detected

Fire

a. Provide proof curtains have been treated with flame retardant.

b. Provide and maintain 18" clearance below sprinkler heads at all times.

c. Discontinue use of extension cord in rooms, medical records, boiler room, and at a nurses station.

d. Power strip shall be plugged directly into electrical outlet.

e. Remove padlock from gate.

f. Provide and maintain service to bedroom door. Door shall close and latch independently and completely.

g. Provide and maintain service to bedroom door. Door shall close and latch independently and completely.

h. Provide permanent wiring or UL approved power tap with 15 amp fuse or circuit breaker. Power tap shall plug directly into electrical outlet.

i. Provide cover plate for electrical outlet.

j. Exit doors shall not be obstructed in any manner. Maintain clear unobstructed access at all times.

k. Provide and maintain escutcheon at all time.

l. Remove all obstructions that enables door to close independently.

m. Provide and maintain service to bedroom door. Door shall close and latch independently and completely.

n. Provide and maintain service to bedroom door. Door shall close and latch independently and completely.

o. Provide and maintain services to magnetic closure.

p. Remove deadbolt lock and unapproved hardware from a screen door in the kitchen.

q. Provide and maintain proper fire lane identification at all times. Signs shall be visible and clear of vegetation at all times.

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INSPECTION REPORT SUMMARY #8

Ron Meyer, Administrator
Oceanview Convalescent Hospital
1340 15th Street
Santa Monica, CA 90404

Number of beds: 227

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Oceanview Convalescent Hospital, located in Santa Monica, on May 15, 2001. The team identified the following issues which were discussed with the facility administrative staff during our exit meeting.

Care Issues

1. The medical records nurses' notes lack proper descriptions and sizing of bruises, wounds and pressures sores. They also lacked detailed descriptions of residents' activities.

2. The physicians' progress notes for many of the residents were unreadable and lacked physical findings documentation.

Environmental

3. There was a heavy build up of mildew in the shower rooms.

4. There were several broken and cracked tiles in the shower rooms.

5. The door frames of several of the shower rooms were rusted near the floor.

6. The shower rooms were dirty and three of them had used linens left on the floor.

7. The shower rooms lack occupancy signs and staff was noted to enter the shower rooms without knocking, which could become a resident's rights issue.

8. There was a moderate odor of urine in the hallways.

9. There were several bent, torn, and/or missing screens on windows, many of which were open allowing flies into the facility.

10. There were several doors leading outside which were found to be propped open, allowing flies into the facility.

11. The kitchen was clean, but there was food in the refrigerator which was not properly labeled.

12. The general housekeeping in the facility was poor. The floors were dirty in some areas and there was trash noted on the floor of the residents' rooms.

Administrative

13. The residents' inventory of personal items were not updated when new items were acquired.

Staffing

Below minimum daily requirements.

Fire

No violations.

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INSPECTION REPORT SUMMARY #9

John Megara, Administrator
Harbor View Center
490 W. 14th Street
Long Beach, CA 90813

Number of beds: 24

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise survey of Harbor View Center, located in Long Beach, on May 16, 2001. The following issues were noted by the team and discussed with the administrative staff during the exit meeting.

Care Issues

1. Documentation in the nurses' notes was incomplete. For example when a resident goes to the acute hospital there is no specific note of their return and their condition upon their return.

2. History and physicals need to include physical examination findings, not just psychological findings.

Environmental

3. There was a build up of mildew and broken tiles in the shower rooms.

4. The rain gutters on the building are rusted, bent and unsecured. They are badly in need of replacement.

5. There were some bent and/or torn screens on windows, which would allow flies and other insects into the facility when the windows are opened.

6. The cover for the drain in the recreation patio area was missing, causing a hazard

to residents.

7. There were multiple areas in the hallways and some rooms that had wall damage.
8. The janitor's closet was left unlocked and unattended, and contained cleaning chemicals.

9. The pay phones were extremely dirty. They need a regular cleaning schedule to prevent the spread of possible infections.

10. There were multiple leaking faucets throughout the facility.

Administrative

11. Temporary passes were being used, but were not properly and completely filled out.

Staffing

Below minimum daily requirements.

Fire

a. Provide a copy of annual fire alarm certification

b. Provide copy of five year automatic fire protection system certification.

c. Provide proper signs for fire department connection and fire control room.

d. Extension cords shall not be used as a substitute for permanent wiring.

e. Remove combustible material from areas near water heaters.

f. Provide accurate emergency evacuation signs for occupants.

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INSPECTION REPORT SUMMARY #10

Regina Trent, Administrator
Fountain Gardens Convalescent Hospital
2222 Santa Ana Blvd.
Los Angeles, CA 90059

Number of beds: 149

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise revisit of Fountain Gardens Convalescent Hospital, located in Los Angeles, on May 17, 2001. The team was pleased to observe that the previously identified issues had been taken seriously by the facility staff. The issues were no longer observed by the team. There were some new minor issues noted and discussed with the facility staff during our exit meeting:

Care Issues

No problems were detected

Environmental

1. There was a build up of mildew in the shower rooms.

2. The gasket on the freezer in the kitchen is in need of replacement.

3. There was a faint odor of urine in one hallway.

4. There was a used glove found in the specimen refrigerator in the utility room.

5. There was an extension cord being used for the television in the office of the DSD.

6. The utility room was very cluttered.

Administrative

No problems were detected

Staffing

Below minimum daily requirements.

Fire

Not applicable

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INSPECTION REPORT SUMMARY #11

Charles Sinclair, Administrator
Alta Vista Health Care
9020 Garfield Avenue
Riverside, California 92503

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise revisit to Alta Vista Health Care, located in Riverside, on May 22, 2001. Many of the previously identified issues had been addressed by the administration. However, we noted the following areas of concern during this visit:

Care Issues

No problems were detected

Environmental

1. The noisy sprinkler head in the ceiling of room #2 is still very noisy.

2. The air-conditioning unit on the roof still appeared to leak.

3. There was gutter damage on the Wheeler Street side of the building. There was also a bent down spout.

4. There were multiple bent screens on windows and there were sliding doors without screens.

5. Ceiling tiles are missing in the eye wash room.

6. The fire extinguishers were not secured and could easily fall on a resident.

7. There was wall damage noted across from room # 2.

8. There is a bad gasket on the freezer in the kitchen which is causing a large amount of condensation outside the door of the freezer and could affect the temperature in the freezer.

9. Shower room occupancy signs are in place, but the staff is failing to use them and still fails to knock before entering.

10. Housekeeping in the residents rooms was poor.

Administrative

No problems were detected

Staffing

Below minimum daily requirements.

Fire

Not applicable.

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INSPECTION REPORT SUMMARY #12

Darlene Watson, Administrator
California Nursing & Rehab Center
2299 North Indian Canyon Road
Palm Springs, CA 92262

Number of beds: 80

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of California Nursing & Rehabilitation Center, located in Palm Springs, on May 23, 2001. The team identified the following issues which were discussed with you and the facility Director of Nurses during our exit meeting.

Care Issues

1. Nurses notes were missing proper details of measurements for injuries and bruises.

Environmental

2. There were several sliding doors which lacked screens. This could allow flies access to the facility as the doors were frequently left open by the staff.

3. The door to the beauty shop was found to be unlocked and contained several chemicals which could be hazardous to confused residents.

4. The door to the staff lounge was left propped open and offered a possible hazard to confused residents.

5. The facility is undergoing extensive remodeling at this time and there were numerous holes in walls which were attributed to this effort.

6. The storage closet by room 5 did not allow for 18 inches of clearance below the sprinkler head.

7. Oxygen tanks were not properly secured in the storage closets.

8. There were some bent screens on facility windows.

9. There was a broken light fixture outside on the south side of the facility.

10. There was a large bag of trash outside on the resident's patio which appeared to have been left for several days. It smelled bad.

11. There was an unattended ladder propped against the building that was left unattended.

12. Housekeeping equipment was left outside where residents could easily trip over it.

13. The IV cart was found to be unlocked and unattended, and contained needles etc.

14. The supply room by room 20 was found unlocked, and should have been locked at all times.

15. There was a soda vending machine in the back hallway which allows unsupervised access to the snacks by confused residents on special diets.

16. There was considerable wall damage in the kitchen

17. There was a raised area of concrete on the front patio which is potentially hazardous to residents walking there.

Administrative

18. Multiple personnel files lacked up to date licenses and certifications.

Staffing

Below minimum daily requirements.

Fire

a. Multiple alarm pull stations did not have the glass retaining rods in place to guard against false alarms.

b. Storage in the closet east of room #5 must be maintained 18" below the sprinkler head.

c. The oxygen storage closet near room #15 must have the larger cylinders

secured by chaining them to the wall studs.

d. Repair the vent in the barber shop to maintain structural fire compartmentalization.

e. Repair the speaker cover plate outside the barber shop for the same reason.

f. The fire rated assembly doors that separate the kitchen from the dining area need to be repaired.

g. There were numerous holes in the boiler room that need to be sealed for the same reason given in #22.

h. Replace the electrical cover plate for the outlet on the west wall of the dining room.

i. Repair the sprinkler escutcheon ring impinging on the sprinkler head in the rehab services room.

j. Replace the vent grill in the director of staff's office

k. Repair the light fixture on the south side of the structure in the lawn area. It is an electrical shock hazard.

l. The biowaste area near the western property line contains combustible materials that are not biowaste and should be stored in an appropriate location or disposed of properly.

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INSPECTION REPORT SUMMARY #13

Carol Van Horst, Administrator
Brighton Place-San Diego
1350 Euclid Avenue
San Diego, CA 92105

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Brighton Place, located in San Diego, on June 5, 2001. The following are the issues noted by the team and discussed in the exit conference held with the administrative staff:

Care Issues

No problems were detected

Environmental

1. There was a build up of mildew in the shower rooms.

2. The gasket on the freezer in the kitchen is in need of replacement.

3. There was a faint odor of urine in one hallway.

4. There was a used glove found in the specimen refrigerator in the utility room.

5. There was an extension cord being used for the television in the office of the DSD.

6. The utility room was very cluttered.

Administrative

No problems were detected

Staffing

No problems were detected

Fire

a. Posted signs and curbs are required in the fire lanes.

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INSPECTION REPORT SUMMARY #14

Mark Larson, Administrator
Country Hills Health Care Center
1580 Broadway
El Cajon, CA 92021

Number of beds: 305

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Country Hills Health Care Center, located in El Cajon, on June 6, 2001. The team identified the following issues which were discussed during our exit meeting:

Care Issues

1. Many physicians are not making the required monthly visits to examine their patients.

2. The updated history and physical forms being used by the facility lack the proper areas for interval history and physical findings showing a physical examination was conducted.

Environmental

3. The treatment carts in the utility rooms on 1-south and 2-north were found to be unlocked and unattended.

4. In the kitchen the gasket on the freezer is badly worn and needs replacing.

5. There was uncovered and undated food in the walk-in refrigerator.

6. In the laundry room the washing machine has a small leak.

7. There was uncovered trash in the laundry room.

8. There was an extension cord being used for the television set in room 230.

9. The mattress on the bed in room 244C is badly torn and needs replacing.

10. The coving is missing near the floor in room 316.

11. Soiled linen is not being properly stored in covered carts.

12. There were tiles missing in the shower room on 1-south.

13. There were soiled linen and used gloves on the floor in the shower room on 2-south.

14. There was mold and soiled linen in the shower stall in the shower room on 4-north

15. Oxygen tanks were not properly secured in the oxygen closets.

16. The doors to the bio-hazardous waste closet were not locked.

17. There were multiple bent, torn and off-track window screens on all sides of the facility. Some screens were missing.

18. There was a trash can with no lid on the west side of the building, which was attracting flies.

Administrative

19. Residents' personal inventory logs are not kept up to date.

20. The surety bond for the resident trust accounts was not sufficient to cover the amount in the account.

Staffing

Below minimum daily requirements.

Fire

a. Power strips with circuit breakers must be used instead of extension cords.

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INSPECTION REPORT SUMMARY #15

John Henning, Administrator
Country Oaks Care Center
830 E. Chapel St.
Santa Maria, CA 93454

Number of beds: 59

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Country Oaks Care Center, located in Santa Maria, on June 19, 2001. The team identified the following issues which were discussed during our exit meeting:

Care Issues

1. The monthly summaries in the nurses' notes were lacking detail, particularly when describing injuries and bruising. They also lacked follow up regarding injuries.

2. The medication administration records lacked signatures for many of the nurses' initials.

3. Annual history and physicals are not up to date in all residents' medical records, and lacked complete physical findings documentation and an interval history.

4. Three of twelve residents checked were in need of nail care, and three of ten needed mouth care.

Environmental

5. There were multiple bent, torn, and off track window screens.

6. There was an odor of urine in the hallways of the facility, particularly in the

Alzheimer wing.

7. At 8:15 a.m., the housekeeper was found to be in the medicine room alone and unsupervised.

8. In room10 the tubing from the oxygen humidifier was stretched across the room where it could trip passing staff or residents.

9. There was uncovered and undated food in the kitchen refrigerator.

10. There were no occupancy signs on shower room doors and staff was noted failing to knock before entering.

11. The drain cover was missing in the west wing shower room by room #1.

12. The key to the supply cupboard on the west wing was left in the lock.

13. There was water damage noted on the shower room wall and door frame in the east wing.

14. The medicine cart was found in the hallway outside the dining room unlocked and unattended.

15. There was a floor polisher stored in a hallway alcove, which allowed confused residents access and could cause injury.

Administrative

16. Two of ten residents checked lacked name bands.

Staffing

No problems detected.

Fire

a. Disconnect Bug Light east side exterior.

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INSPECTION REPORT SUMMARY #16

Janice Harshman, Administrator
Wish-I Ah Care Center
35680 N. Wish-I-Ah
Auberry, CA 93602

Number of beds: 135

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Wish-I-Ah Care Center, located in Auberry, on June 20, 2001. The team identified the following issues which were discussed during our exit meeting:

Care Issues

1. The medication administration records lack signatures for many of the nurses' initials.

2. Some annual history and physicals are not up to date. They also lack an interval history and have few physical findings documented.

3. Some residents lacked name bands.

Environmental

4. There were multiple window screens that were torn, bent or missing.

5. Exterior doors had very worn weatherstripping.

6. Most of the outside walkways were composed of uneven concrete and uneven dirt surfaces.

7. The entire area outside was strewn with rocks and holes in the dirt.

8. The shower rooms lack occupancy designations. There is also a build up of mildew in many of the shower rooms and there was dirty laundry left on the floors

9. The residents' rooms are very sparse and there is little privacy.

10. The facility pay phone is out of order.

11. The facility maintenance areas are very cluttered and unsecured.

Administrative

12. Residents' rights were not clearly posted.

13. Residents' personal inventory records were not up to date.

Staffing

14. The administrator stated he tries to keep a minimum of 3.0 staff level (below the 3.2 minimum required). However, he admitted they were below that figure on at least nine days.

Fire

a. The facility has unprotected wood siding, and the under floor space is unprotected wood frame construction.

b. Corridor doors must be 1 3/4 inch solid bonded wood core doors or equivalent. There must be no impediment to closing the doors.

c. The Laundry room door wa propped open with an unapproved hold open device.

Wish-I-Ah Care Center, Inc.

35680 NORTH WISH-I-AH ROAD
AUBERRY, CALIFORNIA 93602
TELEPHONE AUBERRY (209) 855-2211

April 19, 2002

Special Agent Diana Boutin
2025 Gateway Place, Suite 474
San Jose, CA 95110

Dear Special Agent Boutin:

I recently received the letter which should have been mailed following Operation Guardian's surprise visit/inspection at Wish-I-Ah Care Center on June 20, 2001. Special Agent Supervisor Larry Menard was kind enough to forward a list of findings when the oversight was noticed. He suggested that any comments or plan of correction be sent to your attention.

Corrections were made immediately following the deficient findings. In following up to be sure we remained in compliance the maintenance shop was somewhat messy - rather like my own kitchen in that it depends on what I'm preparing or what I'm cooking or time of day one walks in. On-going monitoring will ensure continuing compliance.

I remember you verbalized the A+ ratings for both our kitchen and laundry. It's nice to hear positive findings along with the negative.

I know your report is public information; in my response, I want to note there were no negative findings of resident care issues.

Sincerely,

Janice M. Harshman, Administrator

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INSPECTION REPORT SUMMARY #17

Lucille Epperson, Administrator
Hope Manor
1665 M Street
Fresno, CA 93721

Number of beds: 155

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise revisit of Hope Manor, located in Fresno on June 21, 2001. The team was pleased to observe that the previously identified issues had been taken seriously by the facility staff. The issues were no longer observed by the team. There were some new minor issues noted as follows:

Care Issues

1. There was food in the third floor medication refrigerator next to medications.

Environmental

2. There were several flies noted in the facility.

3. There was some mildew buildup in the shower rooms.

4. There was an extension cord being used in room 316.

5. There was undated food in the refrigerator.

6. The keys to the janitors rooms were left in the door lock.

7. There was a used glove on the floor in room 226.

Administrative

8. No problems were detected.

Staffing

Below minimum daily requirements.

Fire

Not applicable.

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INSPECTION REPORT SUMMARY #18

Michael Mideiros, Administrator
St. Claire's Nursing Center
6248 66th Avenue
Sacramento, CA 95823

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of St. Claire's Nursing Center, located in Sacramento, on July 3, 2001. The following are the issues noted by the team and discussed in the exit:

Care Issues

1. Call lights were not being answered in a timely manner. One was left unanswered in excess of 20 minutes while staff stood in the hallway near the room (29A).

2. Residents complained that their food sits on the food cart in the hallway without being served. Hot food gets cold before it is served.

3. The progress notes of Dr. Y. do not arrive for more than a month after he visits his patient. The notes then sit in the medical records office until someone files them in the medical record.

4. Annual history and physicals are not up to date and lack complete documentation of physical findings and an interval history.

5. The resident in room 37A complained that her medications are not given to her on time. Her care plan specifies that she is to receive her medications on time. Staff stated that she "can wait."

6. Care plans were not being followed and did not reflect the current needs of the

residents in some instances.

Environmental

7. There was a faint odor of urine noted by the team when they entered the facility.

8. The medication cart was found unlocked and unattended.

9. There were some window screens which were torn, bent or off-track

10. The fence separating the facility property from that of the neighbors is rotting with rusty nails sticking out. It also is falling down in many places.

11. There was a large pile of trash by the facility; chunks of concrete, wood with rusty nails attached, and other hazards.

12. There was a large hole next to a drainage gate which needs to be filled in.

13. There were holes in the stucco near the rear of the building.

14. There was a garden hose left across the pathways and could be a hazard to residents with walkers.

15. The housekeeping supply closet was found to be unlocked and unattended, and contained cleaning chemicals.

16. The maintenance office was found to be open and unattended, and there were several cans of insecticide inside the office.

17. The shower rooms had mildew beginning to build up in the corners of the shower stalls. There were dirty linens left on the floor of two of the shower rooms.

18. There was food in the medication refrigerator next to medications.

Administrative

19. Some residents did not have name bands.

Staffing

No issues were detected**.**

Fire

Unavailable.

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INSPECTION REPORT SUMMARY #19

Jean Priestman, Administrator
Mission Nursing Center
8487 Magnolia Avenue
Riverside, CA 92504

Number of beds: 40

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Mission Nursing Center, located in Riverside, on July 10, 2001. The team was greeted by your staff in a very cooperative manner. The following areas of concern were noted by the team and were discussed in our exit meeting.

Care Issues

1. The door to the central supply room was found open. The room contained syringes and razors, and should have been locked.

Environmental

2. Several hallway handrails in the facility were loose, and some had broken supports.

3. There was a faint odor of urine when the team entered the facility.

4. The fence west of the laundry room is damaged and presents a hazard to residents.

5. There is no latch on the gate to the field east of the laundry room. This field is a potential hazard to residents.

6. The door to an “employee’s only” room was left open and contained housekeeping equipment. To the rear of the room was a closet containing

chemicals which had no locking mechanism. This is a potential hazard to residents.

7. The door to the therapy room was open and contained vending machines which allows unsupervised access to residents.

8. There was a gas pipe located outside the northwest corner of the facility sticking out the ground and creating a potential hazard.

9. There was a broken conduit containing electrical wiring which needs repair located outside the northwest corner of the facility.

Administrative

No problems were detected.

Staffing

Below minimum daily requirements.

Fire

a. Remove the multiplug adapters to the vending machine in the second dining/storage room, the front nurse's desk, N.'s office, the dining room TV and in room 17.

b. Provide six-month service to the hood extinguishing system.

c. Provide quarterly steam cleaning to the plenum and duct to the kitchen hood, or provide documentation that it has been done in the last two months.

d. Remove the extension cords in rooms 9,4, 1, 18, 14 and 15.

e. Remove the surge protector from the multi-plug surge adapter in room 7. Surge protectors shall be plugged into their own outlet.

f. Provide annual maintenance service to the fire alarm system.

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INSPECTION REPORT SUMMARY #20

William Meert, Administrator
Community Care on Palm
4768 Palm Avenue
Riverside, CA 92501

Number of beds: 51

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Community Care on Palm, located in Riverside, on July 11, 2001. The following issues were noted by the team and discussed with the administration during the exit conference:

Care Issues

1. The medication cart was noted to be left unattended and unlocked for at least five minutes in the hallway by rooms 5 & 6. There was no nurse anywhere in the immediate vicinity.

2. The progress notes and history and physical forms completed by one physician, as discussed in the exit, were lacking in physical findings and inadequate for Medi-Cal billing.

Environmental

3. There was a moderate offensive odor noted when the team entered the facility.

4. There was food (candy) found in the medication refrigerator in the med room.

5. There were multiple screens noted to be bent, torn, and/or off track, which can allow flies and other insects into the facility.

6. There were unscreened doors leading outside left open, which can allow flies and other insects into the facility.

7. There was a leaking water heater located near room 17.

8. The shower room by room 15 had several holes in the walls and tile.

9. There were no occupancy or “knock before entering” signs on shower room doors.

10. There was a wheelchair blocking the inside fire doors in the hallway.

11. The employee lounge, containing vending machines, was found open during two separate occasions when the team passed by it.

12. There were several leaking faucets noted in the facility shower rooms and kitchen.

13. There was opened or repackaged food in both the freezer and the refrigerator which lacked a date.

14. There was wall damage noted in the utility room behind the hopper and behind the door.

15. The shower room near the nurses’ station contained an uncovered hamper of soiled linen and used vinyl gloves were found on the floor.

16. One handrail was loose, but was being repaired before the team left the facility

Administrative

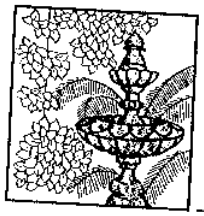
No problems were detected.

Staffing

Below minimum daily requirements.

Fire

There were no violations.



COMMUNITY Care ON PALM

Larry Menard
Special Agent Supervisor
Bureau of Medi-Cal Fraud and Elder Abuse
2025 Gateway Place
Suite 300
San Jose, Ca 95110

Dear Mr. Menard,

On July 11, 2001, Operation Guardian conducted a surprise inspection visit to Community Care on Palm (CCOP). During this positive experience we discovered that there were some issues that needed to be addressed. We felt it was important to give you an update on all of the issues identified by your team:

1. As to the "Moderate offensive odor". It is the policy and practice of CCOP to attend and meet the personal needs of our residents. All resident are toileted and dry garments and underclothing changed every two hours. Showers are given QOD (every other day and as needed). New carpet has been installed in all patient areas. Nursing or housekeeping staff cleans the spills immediately.
2. All Non medication items were removed immediately form the med refrigerator. Storage refrigerators in the nursing medication room have been identified as use for medication cold storage or biological storage. All licensed staff were inserviced to this standard. All food products are to be stored in designated food storage areas.
3. All Screens were removed and repaired by staff. Maintenance will check all screens on windows and doors every week.
4. All staff were given an in-service on identifying open unscreened doors, which can allow flies and other pest into the facility. A complete pest control system is in place to take care of pests if they get in.
5. Maintenance Department had identified the problem as a loose pipe on top of water heater. Maintenance staff repaired the pipe and will monitor that as part of preventative maintenance program.
6. Maintenance Department has identified the problem and patched all holes in the walls and replaced all missing tiles.
7. All "KNOCK BEFORE ENTERING" signs are now hanging on all shower doors.
8. All items were removed from the fire door areas. The staff has been inserviced on Fire and Resident Safety not limited to and including DME placement in recognized fire door areas.

Community Care on Palm
4768 Palm Avenue • Riverside, CA 92501
909/686-2273 • FAX 909/680-6590

9. The issue with the medication cart was addressed immediately. It is the policy and practice of CCOP to maintain safety and security of our residents and medications. In-services were given to all licensed nursing personnel and appropriate discipline taken.
10. All staff has been in-serviced on closing the door to employee lounge when no one is inside. Lounge that contains vending machines will stay closed at all times.
11. Maintenance Department has replaced the leaking faucet in the Dietary Department and shower rooms. A periodic regulatory inspection will be done on all faucets in the facility.
12. All opened or repackaged food will be dated if not used and stored in the refrigerator or freezer. Monitoring will be done by Dietary Supervisor frequently to ensure compliance.
13. At the time of the noted damage, the facility had water damage caused by the city of Riverside. The Maintenance Department has repaired damages to the walls and replaced the vinyl floor.
14. Covered barrels have since been installed in all shower rooms to receive soiled linen during shower experience. In-services on infection control were given for all CCOP staff.
15. All handrails have been repaired and will be put on a full preventative maintenance program by the Maintenance Manager.
16. The Medical Director for CCOP was requested to contact the physician in question to insure compliance to documentation. This request was respected and compliance was met. The Medical Records department currently monitors the patient charts monthly to insure compliance.

Thank you,

Bill Meert
Administrator

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State of California Department of Justice

Office of Attorney General
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INSPECTION REPORT SUMMARY #21

Seth Ellis, Acting Administrator
Motion Picture and Television Hospital, SNF
23388 Mulholland Drive
Woodland Hills, CA 91364

Number of beds: 195

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of the Motion Picture and Television Hospital, SNF, located in Woodland Hills, on July 24, 2001. The team identified the following issues which were discussed during our exit meeting.

Care Issues

1. The monthly summaries in the nurses' notes were lacking detail and in many instances were missing entirely.

2. The medication administration records lacked signatures for many of the nurses' initials.

3. Annual history and physicals are not up to date in all residents medical records. They also lacked interval history's and some lacked physical findings of listed systems.

Environmental

4. There was no weatherstripping on the exterior doors, allowing flying insects in and warm/cool air out.

5. Several sliding doors do not have screens.

6. The pay phone on the second floor is out of order.

7. There were razors left in the shower room across from room 240.

8. There was peri-wash left out in the diningroom.

9. There was food being stored next to medications in the medicine room refrigerators.

10. The fire extinguishers located on the east hallway of the first floor need recharging.

11. The nurses supply rooms were found to be unlocked and unattended. They contained syringes and chemicals.

12. The cupboards containing IV supplies at station 1-west were unlocked and unattended.

13. In the kitchen there were some items in the refrigerator which were not properly dated, possibly due to the fact that they were prepared for lunch.

14. There was soiled linen in shower room 502 for more than one hour.

15. There was mildew beginning to grow in the shower stalls of shower room 502.

16. There was a leaking faucet in shower room 502 which was causing corrosion of the surrounding area.

17. There were soiled gloves left on the floor of shower room 501.

Administrative

18. The personnel files lack documentation of reference checks.

19. Residents' rights were not prominently posted.

20. Personal property inventory records are not being kept up to date.

21. Resident monies are not being returned in the required time period per regulation.

Staffing

Below minimum daily requirements.

Fire

There were no violations.

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INSPECTION REPORT SUMMARY #22

John Franklin, Administrator
Longwood Manor Convalescent Hospital
4853 W. Washington Blvd.
Los Angeles, CA 90016

Number of beds: 180

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Longwood Manor Convalescent Hospital, located in Los Angeles, on July 25, 2001. The team identified the following issues which were discussed with the facility Administrator and Director of Nurses during our exit meeting.

Care Issues

1. The medical records nurses' notes lacked descriptions and were repetitive.

2. The medication administration records lacked nurses' signatures for their initials, and the PRN medications given lacked documentation of the results of the administration.

Environmental

3. There was a strong odor of urine throughout the facility when the team entered.

4. There were multiple torn, bent and off-track screens on residents' windows and sliding glass doors. There also were screens missing.

5. There were wash cloths left in shower room 6 along with two razors.

6. There was mildew building up in the corners of the shower stalls in shower room six. In fact, the shower rooms throughout the facility smelled of mildew and

needed scrubbing.

7. There was food found in the refrigerator in the medication room, along with the resident's medication, in the subacute unit.

8. There were snack and soda vending machines on the patio allowing unsupervised access by residents on specialized diets.

9. The door to the beauty shop was unlocked and unattended, allowing unsupervised access to the utility room where there was a hot autoclave.

10. Resident rooms which open onto the patio area lack screens and are left open by both staff and residents, allowing flying insects into resident areas.

11. The weatherstripping on patio doors is worn and contains many gaps which can allow flying insects into the resident areas.

12. Some hallway handrails were loose.

13. The hallway on nurses station three had carts and wheelchairs on both sides of the hall, preventing free and safe access by the residents.

14. Doorways leading to the patio were propped open, which allows insects into the facility.

Administrative

15. The facility drastically limited the hours during which residents can access their trust account funds, when they should be available during normal business hours.

Staffing

No problems were detected

Fire

a. Test and repair, if need, the automatic sprinkler system.

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INSPECTION REPORT SUMMARY #23

Carolyn Disher, Administrator
Casa Del Rey Care Center
8455 State Street
South Gate, CA 90280

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Casa Del Rey Care Center, located in South Gate, on July 26, 2001. The team identified the following issues which were discussed during our exit meeting:

Care Issues

1. The monthly summaries in the nurses' notes were lacking detail and, in many instances, were missing entirely.

2. The medication administration records lack signatures for many of the nurses' initials.

3. PRN medications given frequently lacked a documented reason for giving the medication and lacked a documented result of the medication administration.

4. Annual history and physicals are not up to date in all residents medical records.

5. The MDS, resident assessments and patient care plans did not match and did not always reflect the current condition of the resident.

Environmental

6. When the team arrived there was a moderate odor of urine in the facility.

7. When the team arrived many of the staff were not wearing name tags.

8. Exterior doors lacked weatherstripping.

9. The window screen south of the front door was bent.

10. The exit door by room 24 does not close properly. The alarm was also turned off.

11. In the kitchen there was a leaking pipe from the ice machine.

12. There were moldy strawberries in the refrigerator.

13. There were undated containers of food in the refrigerator.

14. The lid to the flour bin in the pantry did not fit properly.

15. All the shower rooms had rusted door frames that could be a potential hazard to residents.

16. The shower room next to room 36 was dirty and there was clutter in the drain.

17. The shower room by room 30 had a dirty rag on the floor.

18. There was mildew in the corners of the shower stall in shower room 3.

19. There was a hole in the wall of shower room 2.

20. There was a snack vending machine in the TV room near the business office, which allows unsupervised access to sugar snacks by residents on special diets.

Administrative

21. The personnel files lack documentation of reference checks.

22. The residents' personal property inventory records were not being kept up to date.

Staffing

No problems were detected

Fire

a. Remove any items that may be closer than 18" to the ceiling in the refrigerator stock room.

b. Seal all wall penetrations with fire rated material that is comparable with the original construction in the laundry room.

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INSPECTION REPORT SUMMARY #24

Maria Eriksen, Administrator
Life Care Center of Corona
2600 South Main Street
Corona, Ca 92882

Number of beds: 171

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Life Care Center of Corona, located in Corona, on July 31, 2001. The team identified the following issues which were discussed during our exit meeting:

Care Issues

1. The treatment cart was found unlocked and unattended, stored in the hallway.

2. The emergency cart was located in the soiled/dirty area of the utility room.

3. The monthly summaries in the nurses' notes were lacking detail and in many instances were missing entirely. They lacked detailed measurements of injuries and bruising and lacked follow up documentation of the incident.

4. The medication administration records lacked signatures for many of the nurses' initials.

5. PRN medications given frequently lacked a documented reason for giving the medication and lacked a documented result of the medication administration.

6. The annual history and physicals are not up to date in some residents medical records. They also lacked an interval history and many lacked complete physical findings indicating the physical examination was done.

Environmental

7. There was a faint odor of urine throughout the facility when the team first entered.

8. There were some bent and missing screens on facility windows.

9. The door to the electrical control room was unlocked and unattended.

10. The back door by the physical therapy room would not close properly.

11. There was a noticeable lack of weatherstripping on exterior doors which allowed flying insects into the facility.

12. There was wall and ceiling damage in the laundry room, as well as, a missing window screen in the open window.

13. There was a heavy duty extension cord being used in the medicine room.

14. The floor of the pantry was very dirty.

15. There was mildew beginning in the shower room on 1-south.

16. There was dirty linen left on the floor of the shower room on 1-south.

17. There were ants and rusting door frames in the shower room on 1-south.

18. Some shower rooms had broken tiles and improperly screwed threshold covers.

19. There was clean linen on the floor of the linen closet.

20. There was food in the refrigerator that was uncovered and undated.

21. There was food in the freezer which had been repackaged, but left undated.

Administrative

No problems were detected.

Staffing

No problems were detected

Fire

a. Paint the fire lanes red with the City Municipal Code on it.

b. Install blue dot markers per the City standard.

c. Repair or replace the exit sign in the Recreational Room.

d. Remove locking capabilities on the coolers in the kitchen.

e. Remove all storage around the riser and maintain a clear space of three feet.

f. Repair holes in the drywall in the riser room and the room to the north of the laundry.

g. Clean lint in the area north of the laundry.

h. Provide a current Business Emergency Plan due back by June 15, 2002.

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INSPECTION REPORT SUMMARY #25

Virginia Garcia, Administrator
Pleasant Care of Corona
1400 Circle City Drive
Corona, CA 91719

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Pleasant Care of Corona, located in Corona, on August 1, 2001. The team identified the following issues which were discussed during our exit meeting.

Care Issues

1. It was noted that call lights were very slow in being answered. Staff was observed walking past rooms with flashing calls lights without looking in to see what assistance the resident needed.

2. There were improperly secured oxygen tanks in the oxygen closet.

3. The medication administration records frequently did not have signatures for the nurses' initials.

4. A medication error was noted for the resident in room 109B. The order was for 500 mg of Capoten and this was reflected on the medication administration sheet, however the correct dose should be 50 mg., which is what was being given. The charge nurse was shown the error.

5. The nurses' notes lack detailed descriptions of wounds, injuries, and bruising such as proper measurements and coloring.

6. Follow up documentation of injuries is lacking in the nurses' notes.

7. Physicians' annual history and physical exams lack interval history and details of physical findings indicating a physical examination was done.

8. MDS forms and care plans do not adequately reflect the current condition of some of the residents.

Environmental

9. There was a mild offensive odor present when the team entered the facility.

10. The exterior door at the south end of the facility does not close properly.

11. The awning cover at the south end of the facility needs to have the leaves removed before they become a hazard.

12. There were television wires hanging from the roof in several places around the outside of the facility that could be hazardous to anyone walking in the area.

13. There were multiple windows and sliding doors with bent, torn and off-track screens which allow flying insects into the facility.

14. Many of the exterior doors lacked weatherstripping.

15. There was a ladder propped against the outside of the building near a resident's room which was left unattended for more than an hour.

16. There was an underground waste water, wooden cover which had a hole in it, that is a hazard to anyone walking over it.

17. The fencing around the fire sprinkler system is rotting and is not secured.

18. There was animal feces outside in resident areas.

19. There were broken tiles and a water-filled hole in the patio area.

20. There was a wasp nest located on the east side of the building.

21. There were several hallway handrails that are in need of sanding and refinishing.

22. The pay phone near the rear exit is out of order.

23. There are no occupancy signs on shower room doors which create a privacy issue for residents. The staff was noted to enter the shower rooms without knocking.

24. There were holes in the wall of the shower room on station one.

25. There were broken tiles in the unmarked shower room on station two.

26. There was food left in the medicine room refrigerator next to medications.

27. There were flies and other flying insects noted inside the facility.

Administrative

No problems were detected.

Staffing

No problems were detected

Fire

a. Extension cords can not be used as permanent wiring.

b. An empty space within an electrical panel must be filled with either a circuit breaker or a blank cover.

c. The smoke barrier wall located above the ceiling in nurses station one has several through penetrations that have not been sealed.

d. Both sets of newly installed smoke barrier doors near patient room 345 and near physical therapy do not resist the passage of smoke as evident by the gap between both sets of new doors.

e. The alarm panel batteries are past due for replacement.

f. The sprinkler head located in central supply is missing its escutcheon cup.

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INSPECTION REPORT SUMMARY #26

Jackie Du, Administrator
Pine Ridge Care Center
45 Professional Center Parkway
San Rafael, CA 94903

Number of beds: 101

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Pine Ridge Care Center, located in San Rafael, on August 7, 2001. The team observed the following issues and discussed them with the administrative staff during the exit meeting.

Care Issues

1. Residents complained about staff being noisy at night, and about the call lights not being answered in a timely manner.

2. The medical records revealed a lack of continued assessment and reassessment of residents at risk for falls.

3. Nurses notes were inconsistent, lacked detail and proper descriptions, and were not written in a timely manner. They say nothing about the current condition of the resident.

4. Dr. M. is not signing his progress notes.

5. Dr. A. has not seen the resident in room 21A since 5/2/01.

6. The medication administration records lack signatures for the nurses' initials, as do the treatment records.

7. The treatment records and the medication administration sheets lack initials in

many places, indicating that medication/treatment was not given as ordered. There is no explanation as to why the meds were withheld.

8. There is no explanation given for why PRN medications are given and the result of the administration.

9. Treatment records contain very poor descriptions of rashes and pressure sores, lacking measurements and other vital information.

10. The assessments do not adequately depict the current condition of the resident. There is no follow up as to the cause of various skin conditions.

Environmental

11. The front door of the facility does not close properly.

12. The housekeeping closet was found to be unlocked and unattended, and contained chemical cleaners.

13. There were no occupancy designations on the shower room doors and staff was observed entering without knocking.

14. The interior of the facility had several flies in the hallways.

15. There were large gaps under the exterior doors of the facility. The doors lacked weatherstripping and are likely the main entry point of the flies.

16. There was a mild odor of urine throughout the hallway of the facility.

17. The dirty linen carts were overstuffed, allowing the offensive odor to emanate through the facility.

18. Hallway handrails are in need of sanding and refinishing to prevent injury to the fragile skin of the residents. Several of the handrails had loose screws.

19. Two of the fire extinguishers are close to needing recharging.

20. In the kitchen there were several broken tiles.

21. One of the refrigerators had condensation around the door indicating a worn gasket that needs to be replaced.

22. The chemical cleaner mixer in the kitchen closet is dripping onto the floor and leaking on the wall causing damage.

23. The floorboards under the kitchen sink are badly damaged and coming apart.

24. There was a buildup of mildew in shower room 1, and there are missing tiles in

the same shower.

25. In shower room 3 there is missing caulking and a hole in the tile.

26. In shower room 4 there is a buildup of mildew and cracked tiles.

27. In shower room 5 the caulking is coming out and there was dirty linen left on the floor.

28. The janitor's closet by the nurses' station was unlocked and unattended, and contained chemicals.

29. There were several bent, torn and off-track window screens which allow flies into the facility.

30. Several bushes outside residents windows were overgrown and are blocking the view of bedridden residents.

31. There was an unsecured ladder leading from the outside of the building to the roof with nothing to block residents' access to the roof area.

Administrative

32. Review of the personnel files showed a lack of documentation regarding reference checks.

33. One personnel file of a CNA showed an expired certification and no evidence of current certification verification.

Staffing

No problems were detected

Fire

Not applicable

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INSPECTION REPORT SUMMARY #27

Calvin Callaway, Administrator
Folsom Convalescent
510 Mill Street
Folsom, California 95630

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a revisit inspection of Folsom Convalescent, located in Folsom, on August 8, 2001. The team was disappointed to find that the following areas of concern were again noted by the team despite having discussed the issues with facility management during our original exit meeting on February 14, 2001 that your management recorded and took notes.

Care Issues

1. It was noted that Dr. G. is still not documenting completely on the annual history and physical forms. There is no interim history and no actual physical findings documented.

2. Many call lights went unanswered for more than 5 minutes.

3. There was food in the medication refrigerator at Mill nurses' station.

4. The Natoma "med room" was open and attended only by a CNA. There were medications present and the door should only be accessible in the presence of a nurse.

5. There was no updated history and physical found in the chart of [redacted] C[redacted] in room 7A, since 1993.

Environmental

6. Many of the window screens were bent, which could allow flies entry into the facility.

7. The inside of the facility is badly in need of painting.

8. Outside the facility there was still trash noted all over. The trash containers outside the facility lacked lids which attract flies and other bugs that could easily gain access to the facility and patients with wounds and bedsores. There were also used gloves noted on the ground in several areas where patients lounge outside.

9. Fire extinguishers were not all secured, which could be a danger to patients in the event of an earthquake.

10. Vending machines were located in patient areas which could cause a potential danger, by creating a situation of unsupervised access to the vending machine by patients with choking problems, as well as, those on diabetic, low sodium, or calorie restricted diets.

11. There was a strong offensive odor throughout the facility, a combination of urine, feces and cleaning chemicals.

12. Razors were noted in the utility room, where both doors were left open. The room was usually left unattended.

13. There were several wheelchairs which had cracked and torn backs and seats.

14. There is an uncovered water-filled hole near the water meter in the front of the facility.

15. The side door leading outside does not close properly.

16. The maintenance closet where the floor polisher is stored was left unlocked and unattended, and contained floor polishing chemicals.

17. There were used gloves found on the floor of three of the shower rooms.

18. One of the two washing machines was out of order, and had been for at least two weeks.

19. The ceiling fan cover was not properly attached in the back hopper room.

20. The bathroom in room 103, a five-bed ward, was locked and had an OUT OF ORDER sign on it. According to a staff person, the bathroom has been out of order for “more than a week.”

21. The door to the staff lounge was found to be open and unattended. It was noted that possibly a resident had used a chair in the room as a toilet, having left a large deposit of feces on a fabric-covered chair.

Administrative

22. It is still strongly suggested that an accounting system be established to keep track of items, such as televisions, which have been donated to the facility.

Staffing

Below minimum daily requirements.

Fire

Not applicable.

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INSPECTION REPORT SUMMARY #28

Darlene Watson, Administrator
California Nursing & Rehab Center
2299 North Indian Canyon Road
Palm Springs, CA 92262

Number of beds: 80

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise revisit to California Nursing & Rehabilitation Center, located in Palm Springs, on August 13, 2001. The team was pleased to note that most of the previously identified issues had been addressed and most of the remodeling had been completed. The team did identify the following issues during this visit:

Care Issues

1. The call light in room 19 was left on in excess of ten minutes while at least three staff persons walked by the room without checking on the needs of the resident.

Environmental

2. There were chemicals located outside in an unlocked storage area.

3. There was a ceiling leak noted by room 33 and in room 31 through the fan. Maintenance was aware of the problem and was working on it during our visit.

4. There were fire extinguishers by rooms four and 16 which are in need of recharging.

Administrative

5. Residents' rights were not clearly posted. They had been moved to a book for the

remodeling and have not been properly replaced.

Staffing

Below minimum daily requirements.

Fire

Not applicable.

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INSPECTION REPORT SUMMARY #29

Hope Longeretta, Administrator
Country Villa University Park
230 E. Adams Blvd.
Los Angeles, CA 90011

Number of beds: 88

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Country Villa University Park, located in Los Angeles, on August 22, 2002. The team identified the following issues which were discussed during our exit meeting:

Care Issues

1. When the team arrived and conducted their initial walk through the facility it was noted that there were no water pitchers at the bedside. Staff stated that they had been pulled for cleaning. A system should be in place which assures that the resident always has water (unless ordered otherwise) at the bedside and within easy reach.

2. The listing of residents to be fed and their intake percentages were posted in the diningroom. This is a part of their medical record and a privacy issue. It should not be posted in a public facility area.

3. In general the nurses' notes were lacking detail and in many instances were missing entirely. One resident had notes showing the results of an x-ray, but there was no indication anywhere that the resident had fallen, no description of any bruising or pain. Physician note stated residents complained, but nothing was documented by the nursing staff.

4. Social services notes were incomplete in two instances and unsigned.

5. Some annual history and physicals were not done in a timely manner, most lacked an interval history which should be part of the record.

6. MDS form, assessments and resident care plans are not consistent in their findings and do not always accurately reflect the condition of the resident.

7. The medication administration records lack signatures for many of the nurses' initials.

8. PRN medications given frequently lacked a documented reason for giving the medication and lacked a documented result of the medication administration.

9. Most, but not all, residents had name bands, but some were very dirty and couldn't be read.

10. Several residents had ragged nails which could injury fragile skin.

11. The facility has a high percentage of residents who have a diagnosis of Diabetes listed. However, they are on no special diet, no diabetic medications and their lab work are normal. This needs to be checked and the records corrected as appropriate.

Environmental

12. There were some window screens throughout the facility which were bent or off-track, which allows flies into the facility when the windows are open.

13. The west front door does not close properly.

14. The basement door leading outside is severely water damaged and provides no security for the building and its residents.

15. The fire extinguisher in the basement needs recharging.

16. There was no locking mechanism on the elevator which leads down to the basement and contains a variety of hazards to residents.

17. There were no occupancy signs on the shower rooms and staff was observed not knocking before entering the shower rooms, violating residents' privacy.

18. There was peri-wash, room freshener and chemical cleaners in an unlocked storage area across from room 215.

19. There was a loose hallway handrail by room 216.

20. The central supply room on station two was locked, but the door had been left open.

21. There was a wire coat hanger and several articles of clothing lying on the floor of the east hallway.

22. The medical records' room is located by an exit door, which was unlocked. Inside, the records' room was unlocked and unattended.

23. There was soiled linen left in the tub across from room 112.

24. Many of the lap buddy's checked were cracked and torn and are a hazard to the fragile skin of elderly residents.

25. Residents complained about the facility being too hot.

26. There was food in the refrigerators which were uncovered and undated.

Administrative

27. The personnel files lack documentation of reference checks.

Staffing

No problems were detected

Fire

No violations.

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INSPECTION REPORT SUMMARY #30

Grant Edgson, Administrator
Magnolia Convalescent Hospital
8133 Magnolia Avenue
Riverside, CA 92504

Number of beds: 120

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Magnolia Convalescent Hospital, located in Riverside, on August 28, 2001. The team identified the following issues.

Care Issues

1. The medical supplies room on station two was found with the door open and no one in attendance. There were syringes etc. inside.

2. There was food in the medication refrigerators next to medications.

Environmental Issues

3. The vents on the roof of the facility were emitting a foul odor.

4. There were multiple bent window screens.

5. The concrete on the patio was uneven in many small areas, which could cause a hazard to residents walking in the area.

6. The front smoking area concrete also needs patching.

7. There was a strong odor of urine in the facility hallways.

8. There was food in both the kitchen refrigerator and freezer that was undated.

9. Shower room 3 has a build up of mildew in the shower stall, a burned out light bulb, dirty wet linen left on a chair in the room, and a capless tube of toothpaste left on the shelf.

10. The print of the resident's rights is very small and unreadable by older persons.

11. There were snack and soda vending machines located on the patio allowing for unsupervised access by residents on specialized diets.

12. There was a leaking faucet in the laundry room.

13. The outside of the facility was littered with trash.

14. The sliding doors to the patio had been left open without the screens being closed, and allowing flies into the facility.

15. There were no occupancy designations on the shower room doors and staff was noted to be entering without knocking. This could develop into a privacy issue for residents.

16. There was no alarm or wandergard on the front door. Wandering residents could easily leave without detection.

17. There was no light in the oxygen closet.

18. Cookies in the kitchen pantry were not properly covered.

19. The housekeeping storage room by room 48 was found to be locked, but the door was left open.

20. There was no alarm or wandergard on exit doors.

21. The door to the employee lounge was left open despite a sign ordering that it be kept closed at all times.

22. The janitor's closet by the employee lounge was found to be unlocked and unattended, and contained chemicals.

23. The outside storage by the laundry was open and unlocked and contains chemicals.

Administrative

No problems were detected.

Staffing

Below minimum daily requirements.

Fire

a. Provide a copy of the required five year certification for the fire sprinkler system.

b. Provide service to the hood system in the kitchen. Systems are to be serviced every six months.

c. Repair the required fire doors to the wash room and soiled linen room to close and latch properly.

d. Secure all oxygen tanks at all times.

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INSPECTION REPORT SUMMARY #31

Ms. Yuba Radojkovich, Administrator
Pleasant Care Nursing & Rehabilitation Center
2828 Meadowlark Drive
San Diego, CA 92123

Number of beds: 305

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians survey team conducted a surprise revisit of Pleasant Care Nursing & Rehabilitation Center, located in San Diego, on August 4, 2001. Most of the issues identified during the survey of September 14, 2000 had been addressed by the facility staff. The following issues were identified during the revisit.

Care Issues

1. There was an unusually high quantity of discontinued medications in the med rooms which had not been destroyed.

2. The keys to the medication room on station four were found to be in the door lock and had been left unattended.

3. The call light for room 251 went unanswered for a period in excess of six minutes.

4. There were call lights in three rooms that were found to be inoperative

5. Resident [redacted] J. in room 512 objects to being bathed by male staff.

6. Resident [redacted] J. also disclosed that her walker was misplaced by facility staff . Staff promised [redacted] J. a replacement, however it has not arrived.

Environmental

7. Oxygen tanks were found improperly chained in the oxygen closet.

8. The hallways on station four had a strong odor of urine throughout the survey

9. Multiple unscreened doors and windows were found open, allowing flies in and out of the facility.

10. There were flies noted in the facility hallways and some residents' rooms.

11. There were no occupancy designations on shower room doors.

12. There were several bent screens noted on the windows and sliding doors of the residents' rooms.

13. Obstacles were noted on both sides of the facility hallways, which could be a hazard to residents during an emergency.

14. The housekeeping closet on stations three and four were found to be unlocked and unattended, and contained chemicals which could be a danger to residents.

Administrative

15. The facility staff still failed to keep residents personal property inventory sheets updated.

Staffing

No problems were detected

Fire

Not applicable.

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INSPECTION REPORT SUMMARY #32

Gary Stork, Administrator
Carlsbad By The Sea
2855 Carlsbad Blvd.
Carlsbad, CA 92008

Number of beds: 33

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Carlsbad By The Sea, located in Carlsbad, on September 5, 2001. The team identified the following issues which were discussed during our exit meeting.

Care Issues

1. Dr. S. is not making the required monthly visits in a timely manner.

2. The treatment cart was found to be unlocked and unattended, and containing medicated treatment products.

Environmental

3. Doors and windows throughout the facility were left open without screens, which could allow flies into the facility causing problems for residents with wounds.

4. One item in the resident's kitchenette was not completely covered.

5. The utility room by the housekeeping closet contained iodine that should be kept in a locked cupboard.

6. The housekeeping closet across from room 352 was found to be unlocked and unattended, and contained cleaning chemicals.

7. There were nail care products containing chemicals left unattended in the activity room.

8. There was a microwave in the activity room that could cause a potential problem for residents with pacemakers.

9. The activity room contained a refrigerator for staff that contained food which was easily accessible to residents on restricted diets.

Administrative

10. Two of the six personnel files reviewed had CNA's certificates that were expired. There was no documentation stating that this had been checked.

Staffing

No problems were detected

Fire

Unavailable.

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INSPECTION REPORT SUMMARY #33

Chris Boyd, Administrator
Sharp Chula Vista Medical Center SNF
751 Medical Center Court
Chula Vista, CA 92010

Number of beds: 100

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Sharp Chula Vista Medical Center D/P SNF, located in Chula Vista, on August 6, 2001. The team identified the following issues:

Care Issues

1. The medication refrigerator contained food next to the medications.

2. Dr. L. has not done annual history and physical exams on his patients for the past two years.

3. The nurses notes were lacking detail and in many instances were missing entirely. Incidents were not documented as being followed up. Descriptions of injuries and bruising lacked proper measurements and color descriptions.

4. The medication administration records lack signatures for many of the nurses initials.

5. PRN medications given frequently lacked a documented reason for giving the medication and lacked a documented result of the medication administration.

6. Some MDS form, assessments and resident's care plans do not appropriately reflect the current status of the resident.

Environmental

7. Several residents complained that the bathroom doorways are too narrow for wheelchair access. They would also like door knobs on the inside of the doors to make it easier to close the opposing bathroom door.

8. There were some patio screens that were off-track.

9. There are multiple windows that have screens with a 5 x 5 inch hole which allows flies and other insects into the facility.

10. There door to the laundry room was being kept open by a glove stuffed into the door jam. There were laundry chemicals inside the room.

11. There were soiled towels in shower room 2.

12. The utility room next to room 4 was found to be open and unattended, and contained chemicals.

13. The east wing utility room door was propped open with a full container of laundry detergent, and contained multiple soiled linen carts that were overflowing with dirty linen.

14. The storage closet by the recreation room was found to be unlocked, unattended, and contained chemicals.

15. There were snack and soda vending machines in the recreation room which allows unsupervised access to residents who are on specialized diets.

Administrative

16. The residents personal property inventory records are not kept up to date. Many of the labels used to identify residents property are peeling off.

17. Staff personnel files lack documentation of reference checks.

18. CNA's [redacted] M. and [redacted] G. have notes in their file congratulating them for passing the written examination. There is no certification in the file and no documentation stating that staff is attempting to verify the certification.

Staffing

No issues were detected**.**

Fire

Unavailable.

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INSPECTION REPORT SUMMARY #34

Steve Shipley, Administrator
Winchester Convalescent Care Center
1250 S. Winchester Blvd.
San Jose, CA 95128

Number of beds: 166

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise revisit of Winchester Convalescent Care Center, located in San Jose, on September 18, 2001. The team was pleased to observe that the previously identified issues had been taken seriously by the facility staff. Several of the issues were no longer observed and many of the issues were still in the process of being repaired. There has been substantial remodeling, although there are still issues that need to be completed. The following was noted during our revisit:

Care Issues

No issues were detected

Environmental

1. There was a still a strong odor of urine noted throughout the facility.

2. The supply room in the sub acute unit was found to be unlocked, unattended, and contained supplies that could be hazardous to confused residents.

3. The patio doors and screens were open allowing flies into the facility that can be a problem for residents with wounds.

4. There were snack and soda vending machines on the patio, an area which allows unsupervised access by residents who may be on specialized diets.

5. There were still no occupancy signs on the shower room doors and staff was still observed entering without knocking.

6. There were several screws sticking out of the wall in room 32.

7. There is a worn gasket on the refrigerator in the kitchen which could lead to less control of the inside temperature.

8. There were still window screens that were bent, torn and off-track.

9. There was a ladder to the roof which had no mechanism for securing it from allowing confused residents access to the roof.

10. There was tile damage noted in the trash room by room 36.

Administrative

No problems were detected

Staffing

Below minimum daily requirements.

Fire

Not applicable.

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INSPECTION REPORT SUMMARY #35

Jean Jardine, Administrator
Westgate Rehab & Specialty Care Center
1601 Petersen Ave.
San Jose, CA 95129

Number of beds: 216

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Westgate Rehab & Specialty Care Center, located in San Jose, on September 19, 2001. During the inspection the team noted the following issues:

Care Issues

1. There were three residents at various times during the inspection who were noted to be improperly dressed in hospital gowns with the back open and no underwear.

2. One LVN from the registry, [redacted] C., was signing the medication administration sheets in advance of giving the medication.

3. A registry LVN, [redacted] H., was not initialing the medication administration records as she passed meds. When confronted with the question of why she wasn't signing, H. said she always waits until she has time later.

4. Staff is not properly using privacy curtains when caring for residents. This was noted several times by various members of the team.

5. Residents complained about staff yelling up and down the halls, especially on the 3-11 shift.

6. Residents complained about staff on the 3-11 shift being rude and uncaring.

7. We observed staff ignoring call lights as they passed rooms if the room was not assigned to them. Lights were not answered in a timely manner, many exceeding ten minutes.

8. It was noted that the physicians of Kaiser patients are not signing their progress notes and many do not sign their order sheets.

Environmental

9. There were multiple bent and torn window screens which allow flies into the facility.

10. The back door to the facility was unlocked and had no alarm system which would alert the staff to wandering residents.

11. There was a wasp nest noted in the Alzheimer unit breeze-way. This was brought to the attention of the maintenance staff who acted immediately.

12. There were multiple sliding door screens that were off-track and did not close properly due to poor alignment.

13. The shower room occupancy signs were not being properly used by the staff and they failed to knock before entering the shower rooms.

14. The soiled linen carts were not closed properly and there were offensive odors emanating from them.

15. There was a power strip left in the hallway by nurses station four that was plugged into the wall, but nothing was plugged into it. It posed a hazard to safe passage through the hallways.

16. The patio door by station three does not close properly.

17. Many of the soiled linen containers did not have lids.

18. An unmarked shower room by station two was missing grout, had dirty gloves on the floor, and soiled linen lying on a chair.

19. An extension cord was being used in room 49 to connect to a fan.

20. In the Alzheimer unit the shower room across from room 228 had a broken drain cover. This could be a hazard for residents using the shower. There also was soiled linen on the floor, a broken tile, and a hydro force container in the room containing floor cleaner, which was left unattended.

21. A room marked “Oxygen Room” is actually a shower room and could be a hazard as the facility uses frequent registry staffing and they may need oxygen in a hurry.

22. Heavy equipment was left unattended in the hallway at 0920 hours.

23. There was floor damage noted in room 225.

24. At 0920 hours, the housekeeping cart was observed unattended in the hallway. It contained cleaning chemicals.

25. There was a heavy buildup of mildew in the shower stalls of the shower rooms.

26. There was a water hose left stretched out and unattended on the patio.

27. There were sprinkler pipes left exposed by a hole dug outside the facility.

28. The railing leading up the ramp to the dry goods storage area is very loose.

29. The outside electrical breaker rooms were left unlocked and unattended.

30. The water heater room door was left unlocked and unattended and contained lawn cutting equipment.

31. The washing machine in the laundry room has a minor leak

32. The hallways near room 138 were cluttered with chairs and carts blocking easy passage for residents.

33. The patio door by station 3 does not close properly.

34. Some food in the refrigerator was not dated and some was not properly covered.

35. The floor board in room 29 is coming off the wall.

Administrative

36. Personnel files did not contain current license/certifications for many staff including licensed nurses. They also lacked documentation of reference checks.

Staffing

Below minimum daily requirements.

Fire

a. Provide exit signs in kitchen area.

b. Annual certification for fire alarm system.

c. Provide circuit breaker strips. No extension cords are allowed.

d. Keep all storage 18" below sprinklers.

e. Remove canopy from outside patio. Permits must be obtained from building to build permanent patio cover.

f. Mounted BC fire extinguishers in kitchen near generator with no smoking signs.

g. Provide sheet rock replacement in kitchen boiler room.

h. Convert exit doors to thumb bolts where indicated.

i. Recharge fire extinguisher in station five work room.

j. Inventory of corrosives/oxygen/LPC/ to be provided on a HazMat business plan.

k. Remove slide bolt from laundry doors.

l. Install proper door in Station five laundry storage yard.

m. Generator in rear of station five area needs to be kept free and clear of storage. Provide protection device in generator area with BC extinguisher and no smoking signs.

n. Secure LPG containers.

o. Mount fire extinguisher in shed. Storage to be kept 18" below ceiling. Two feet if non sprinklered.

p. Provide quarterly fire drill records.

BEVERLY HEALTHCARE

August 6, 2002

Mr. Larry Menard, Special Agent Supervisor
Bureau of Medi-Cal Fraud and Elder Abuse
Operation Guardians
2025 Gateway Place, Suite 474
San Jose, California 95110-1006

Dear Mr. Menard:

We are in receipt of your letter of June 13, 2002 that was received in our office on August 5, 2002.

We are in the process of addressing those issues noted in your correspondence and to provide for ongoing monitoring of these areas.

If you have further questions please contact me.

Sincerely,

Ben Laub
Executive Director

Westgate Rehab and Specialty Care Center
1601 Petersen Avenue • San Jose, CA 95129
(408) 253-7502 • FAX (408) 253-7859

YOUR PATHWAY HOME

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INSPECTION REPORT SUMMARY #36

Kathy Tucker, Administrator
Ashby Care Center
2270 Ashby Ave.
Berkeley, CA 94705

Number of beds: 31

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Ashby Care Center, located in Berkeley, on September 20, 2001. The team identified the following issues which were discussed during our exit meeting:

Care Issues

1. In room 9, resident Ds' medical record contains a history and physical form which refers to a previous physical examination which is not in the chart.

2. The Kaiser physicians seeing residents at the facility are not signing progress notes or monthly orders, and are not seeing the residents on a regular basis.The monthly summaries in the nurses' notes were lacking detail and in many instances were missing entirely.

3. The medication administration records lack signatures for many of the nurses' initials.

4. PRN medications given frequently lacked a documented reason for giving the medication and lacked a documented result of the medication administration.

5. Annual history and physicals are not up to date in all residents medical records.

6. Patients of Dr. R. frequently do not have signed orders or progress notes.

Environmental

7. Both gates to the side storage area were unlocked and contained heavy equipment.

8. The door to the chemical storage was unlocked and unattended.

9. There was one badly torn screen on the sliding door to room 4.

10. There was a ladder lying on the ground by the fence.

11. There was a loose hallway handrail by room 8.

12. There was an extension cord being used in room 5.

13. There is no light in the oxygen closet, and it needs cleaning.

14. The small oxygen tanks were not properly secured and could fall over.

15. The janitor's closet was found to be unlocked, unattended, and contained chemicals.

16. Housekeeping is failing to sweep and/or mop behind doors, resulting in a dirt build up.

17. Soda vending machines are located outside where residents can have unsupervised access to items that are not on their specialized diets.

18. There was soiled linen on the floor of the shower room across from room 3.

19. There was undated prepared food in the kitchen refrigerator.

20. There was food in the medicine room refrigerator next to the medications.

21. There was food in the refrigerators that were uncovered and undated.

Administrative

22. Residents' rights were not properly posted.

23. The personnel files lack documentation of reference checks.

Staffing

No issues were detected.

Fire

a. Provide hood and duct system for the stove in the kitchen.

b. Discontinue use of extension cords as a means of permanent wiring in kitchen.

c. Provide a working smoke detector for each sleeping room.

d. Remove obstructions and/or storage from hallways.

e. Exits shall not be obstructed in any manner.

f. Develop an emergency procedure plan and emergency procedures training for employees.

g. Provide 18" clearance in storage closets from all sprinkler heads.

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INSPECTION REPORT SUMMARY #37

Monica Choperena, Administrator
Beverly Healthcare-Monterey
23795 W.R. Holma Highway
Monterey, CA 93940

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise revisit to Beverly Healthcare-Monterey, located in Monterey, on October 1, 2001. The facility showed improvement in most of the areas previously identified as problems when we visited in September, 2000. The following were noted by the team and we are sure they will receive the same attention as our previous concerns:

Care Issues

No problems detected.

Environmental

1. There was one screen which had a small hole in it.

2. There were full and empty bottles of chemicals outside the back door, north side of the building, which could be hazardous to confused residents.

3. There was a faint odor of urine in various parts of the facility.

4. There was soiled linen on the floor of the bathroom in room 2, on more than one occasion during our brief visit.

5. There is a large hole in the wall of room 58 near the baseboard, and a chipped electrical outlet cover.

6. The central supply was found to be unlocked and unattended, and contained hazardous items such as syringes.

7. The beauty shop door was found to be unlocked and unattended, and there were chemicals left out.

Administrative

8. The print on the resident's rights was difficult for some older persons to read.

Staffing

Below minimum daily requirements..

Fire

Not applicable.

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INSPECTION REPORT SUMMARY #38

Floyd Hardcastle, Administrator
Carmel Convalescent Hospital
Highway 1 & Valley Road
Carmel, CA 93921

Number of beds: 65

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Carmel Convalescent Hospital, located in Carmel, on October 2, 2001. The team identified the following issues:

Care Issues

1. The medication refrigerator was left unlocked, unattended, and contained medications.

2. At least four residents were seen walking the halls or sitting in wheelchairs with no shoes, socks or other foot covering.

3. At least four wheelchairs were noted to have torn and cracked seats, backs, and armrests.

4. The nurses' notes lacked detail and in many instances were missing entirely. Incidents were not documented as being followed up. Descriptions of injuries and bruising lacked proper measurements and color descriptions.

5. The medication administration records lacked signatures for many of the nurses' initials.

6. PRN medications given frequently lacked a documented reason for giving the medication and lacked a documented result of the medication administration.

7. Some annual history and physicals are not up to date in residents' medical records. They also lacked an interval history and complete physical findings.

8. Residents were not being seen on a timely basis by the attending physician.

9. Resident L. was admitted 8/7/01 and had no signed doctor's orders by her attending physician and no progress note.

10. Weekly weights noted in the care plans were not documented as done.

11. MDS form, assessments and residents' care plans do not appropriately reflect the current status of the resident.

Environmental

12. There were multiple windows and doors on the facility which lacked screens. The administrator stated that he had a waiver for this, but was unable to produce it. There were flying insects both dead and alive in the facility.

13. There were several windows that had broken and badly cracked glass.

14. There was a large pile of trash/junk on the side of the facility which is a hazard to staff, visitors, and residents who may wander outside.

15. The concrete stairway leading to the lower level outside is uneven and a hazard.

16. The walkways around the outside of the facility are all uneven, do not allow for wheelchair and walker access, and are potential hazards to anyone walking around the grounds.

17. There is a partially covered sink hole on the side of the facility which needs to be completely covered.

18. There is a TV cable hanging down, blocking clear and safe passage down one outside corridor.

19. There were large deposits of rodent droppings in multiple areas of the facility. Droppings were found on open packages of diapers, next to medications and syringes, etc.

20. There was an unlocked door in the diningroom that led to a very hazardous area of pipes, rodent droppings, supplies etc. The entire area was extremely dangerous and a hazard to the safety of the residents.

21. There was floor damage in the dining room.

22. There were open boxes of supplies where rodents were nesting.

23. The rooms and hallways had very hot radiators which had no protection for the residents to prevent burns.

24. There were several leaks noted from the pipes in the basement.

25. There were soiled gloves found on the floor in various resident rooms and other areas of the facility.

26. There was a hole in the wall of the rehab room.

27. The drain hole in the shower room by room 110 is uncovered.

28. The janitor's supply closet had no lock, and contained chemical cleaners.

29. The hallway handrails are badly in need of sanding and refinishing to prevent injury to the fragile skin of the residents.

30. The janitor's closet on the second floor has a leaking faucet.

31. The handrail by rooms 216 and 303 are very loose.

32. There was food in the refrigerators that were uncovered and undated.

Administrative

No issues were detected.

Staffing

Below minimum daily requirements.

Fire

a. The deputy was unable to test the generator. The generator testing documentation has not been completed since January 2001.

b. Exit lights are out at the second floor nurses station and above the exit door, north end.

c. Exit signs missing at required main exit door. Doors leading into dining room and exit door leading out from the dining room are missing signs.

d. Exit sign above the kitchen door shows only one direction. Main exit with ramp is in the opposite direction that the sign indicates.

e. An electrical panel wall located in the first floor dining room has a large penetration at the bottom of the wall.

f. The fire alarm documentation was not available at the time of the survey.

g. The local alarm initiated with a bell sounding from the fire alarm system, not a buzzer or distinct sound of its own. The staff asked why the alarms were not ringing downstairs. Staff did not know the difference.

h. The Christmas tree located in the front entrance area does not have a fire retardant tag.

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INSPECTION REPORT SUMMARY #39

Julie Alsop, Administrator
Salinas Rehab and Care Center
637 E. Romie Lane
Salinas, CA 93901

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Salinas Rehabilitation and Care Center, located in Salinas, on October 3, 2001. The team identified the following issues:

Care Issues

1. It was noted at 10:00 a.m., more than 20 residents had been moved into the dining room and left around tables, most looking at their laps, without any stimulation or activity. Music was finally turned on at 10:35 a.m., but there was still no visual stimulation.

2. Dr. J. is not signing the physicians' orders in a timely manner. When he does sign, he fails to date them.

3. Several physicians are not visiting their patients in a timely manner as required by regulation.

4. Many of the physician's progress notes lack physical findings indicating that there is no examination being done as required for Medi-Cal payment.

5. The nurses' notes lacked detail. Incidents were not documented as being followed up. Descriptions of injuries and bruising lacked proper measurements and color descriptions.

6. The medication administration records lacked signatures for many of the nurses'

initials.

7. PRN medications given frequently lacked a documented reason for giving the medication and lacked a documented result of the medication administration.

8. Some annual history and physicals are not up to date in residents medical records. They also lacked an interval history and complete physical findings.

Environmental

9. There were several bent, off-track or missing screens on windows and patio doors.

10. A significant amount of fruit has fallen from the tree on the patio onto the walkway creating a slippery hazard.

11. The bolts on the fencing on the west side of the building are extending several inches and cause a hazard to anyone walking too close to the fence.

12. The garden hose was not properly stored on the east side of the building and created a hazard to walking.

13. The maintenance storage in the back of the facility was found to be unlocked and unattended and contained several items which could be dangerous to confused or wandering residents.

14. There was a faint odor of urine throughout the facility when the team entered. It had dissipated by the time we left.

15. There was food in the medication refrigerators next to medication.

16. Several hallway handrails are sticky and in need of sanding and refinishing.

17. The housekeeping storage by room 21 was found to be unlocked, unattended, and contained housekeeping equipment and cleaning supplies.

18. Snack and soda vending machines were located in an area that allows unsupervised access by residents who may be on specialized diets.

19. There was dirty linen found on the floor of the shower rooms.

Administrative

20. Residents' personal property inventory records are not up to date.

Staffing

Below minimum daily requirements.

Fire

Unavailable.

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INSPECTION REPORT SUMMARY #40

Laurie Shea, Administrator
Santa Barbara Convalescent Hospital
540 W. Pueblo
Santa Barbara, CA 93105

Number of beds: 62

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Santa Barbara Convalescent Hospital, located in Santa Barbara, on October 10, 2001. The following are the issues noted by the team and discussed in the exit conference held with the administrative staff:

Care Issues

1. The nurses notes are repetitive and lack detailed descriptions and measurements of bruises and wounds.

2. The MDS assessments are missing and/or incomplete in most of the files reviewed.

3. Many of the physicians orders are unsigned and those that are signed lack dates on the signatures.

4. The medication records are missing initials in some instances, lack reasons for meds that were not given as ordered, and PRN meds lack documented reasons for the administration of meds and results of the administration.

Environmental

5. There were several bent and torn screens on residents windows.

6. The gasket on the freezer in the kitchen is in need of replacement.

7. There was a faint odor of urine in the facility upon entry of the survey team.

8. There were paint cans and assorted spray cans found outside a storage shed near the laundry room.

9. Fencing rails on the west side of the facility are loose. Also, we discussed the potential danger of present fencing.

10. Several small wasp nests were found under eaves of the facility.

11. There was a hose left coiled outside residents' rooms on back patio area, a potential hazard to residents.

12. There is no weather stripping on the front doors allowing substantial space for insects to enter and cold air to enter facility.

13. Handrails were loose next to room 20 and between rooms 25 and 26. Also, some of the handrails are in need of sanding to prevent injury to residents.

14. In the kitchen refrigerator there were some items improperly covered, and some lacked dates. There was also uncovered brown sugar found in the pantry.

15. The tub room is very dark, making proper skin checks difficult when giving baths.

16. A dirty towel was found on the floor of the shower room across from room 17.

17. There was floor damage noted in room 24.

18. The gates on the west side of the facility have no locks and allow easy escape routes to wandering residents, as well as, unsupervised access to patients' sliding glass doors.

19. The area between the two west gates is hazardous to residents and staff due to soil erosion.

Administrative

No issues were detected

Staffing

20. There were several days noted in the ten week period reviewed that lacked the required 3.2 hours per patient day of staffing, many of which were below 3.0 hours.

Fire

Unavailable.

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INSPECTION REPORT SUMMARY #41

Gerald Hardy, Administrator
Ventura Estates Health Manor
915 Estates Drive
Newbury Park, CA 91320

Number of beds: 50

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Ventura Estates Health Manor, located in Newbury Park, on October 11, 2001. The team identified the following issues which were discussed during our exit meeting:

Care Issues

1. The nurses' notes were lacking detailed descriptions of wounds, injuries and bruising and lacked follow up documentation.

2. The medication administration records lacked signatures for many of the nurses' initials.

3. PRN medications given frequently lacked a documented reason for giving the medication and lacked a documented result of the medication administration.

4. Annual history and physicals are not up to date in all residents medical records. Most lacked physical findings of an examination and all lacked an interval history.

5. Many residents lacked name bands.

6. Five of twelve residents were in need of nail care for dirty and ragged nails.

7. Water pitchers were out of the reach of several residents who were either bedridden or in chairs by their beds.

8. Call lights were not answered in a timely manner, and staff was noted to pass rooms with call lights on without looking in to see what the resident needed.

9. Care plans and assessments did not always accurately reflect the current status of the resident.

Environmental

10. There was a noticeable odor of urine when the team entered the facility.

11. The eave trim is rotting in several places around the building.

12. The door to the bio-hazard waste was locked but open.

13. Outside access around the building was potentially hazardous to wandering residents.

14. The alarms to all the exterior doors were turned off which defeats the purpose of having the doors alarmed for resident safety.

15. Several window screens are bent and/or torn allowing flies into the facility.

16. The kitchen's back door to the facility will not stay closed properly.

17. The hallway handrails in several areas need sanding and refinishing to prevent skin tears to the residents' fragile skin.

18. The Manor nurses' station treatment cart that contains medicated treatment supplies was found in the hallway unlocked and unattended.

19. Linen carts and trays were stacked near the south side exit doors despite signs to the contrary.

20. Some storage bins in the pantry were left uncovered.

21. Food in the refrigerator was left uncovered and undated.

22. There were outdated items in the walk-in refrigerator.

23. There were dry food goods stored with corrosive materials and a lawnmower.

24. There was a hole in the wall and in the ceiling of storage room 3. The door was propped open with an electrical panel inside and multiple items were jammed into the room and in an area designated to keep clear.

25. The outside door to the soiled linen area does not close properly.

26. The employee lounge door was propped open when the sign on the door states it is

to be kept closed at all times.

27. There is a snack vending machine in the multipurpose room allowing residents on specialized diets unsupervised access to foods not on their diets.

28. The weatherstripping is missing on the front door and allows flies into the facility.

29. Dirty linen carts were overstuffed allowing offensive odors to emanate through the halls.

Administrative

30. The personnel files lack documentation of reference checks.

Staffing

Below minimum daily requirements.

Fire

Unavailable.

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INSPECTION REPORT SUMMARY #42

Maricela Santana, Administrator
Victoria Care Center
5445 Everglades Street
Ventura, CA 93003

Number of beds: 188

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a revisit at Victoria Care Center, located in Ventura, on October 12, 2001. The team was pleased to see that the issues noted during our initial inspection have been addressed and were no longer present. The following new issues were noted by the team and brought to the attention of the administrator:

Care Issues

No problems were detected

Environmental

1. There was uncovered food in the refrigerator.

2. There was a kitchen worker wandering around the kitchen with an open, bleeding wound. Although the worker is employed by the assisted living facility, the food prepared in the kitchen is served to the SNF residents. The kitchen staff should be aware of blood-borne pathogens and precautions that must be taken.

3. Gaskets on the kitchen refrigerator need replacement.

4. Two hallways were being blocked on both sides rather than keeping equipment to one side, a potential hazard to residents if an emergency occurs.

5. Food was found in the medication refrigerator on one station.

6. Weatherstripping is needed on the front door of the facility to prevent loss of heat/air conditioning and to prevent flying insects easy access inside the facility.

Administrative

No problems were detected

Staffing

Below minimum daily requirements.

Fire

Not applicable.

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INSPECTION REPORT SUMMARY #43

Gary Devoir, Administrator
Care With Dignity Convalescent Hospital
8060 Frost Street
San Diego, CA 92123

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Care With Dignity Convalescent Hospital, located in San Diego, on October 16, 2001. The team identified the following issues which were discussed during our exit meeting:

Care Issues

1. The resident in room 26A was improperly exposed to passers by when he was being cared for by the staff and the privacy curtains were not drawn.

2. Dr. S. is not making regular required visits to see his patients.

3. Dr. E. is writing very brief progress notes which do not indicate that he is doing an examination of the resident.

4. Physicians progress notes are in with the nurses weekly notes which makes finding pertinent information very difficult, and the charts are thinned regularly taking the physicians' notes to storage. The staff is inconsistent in its use of the "doctors' progress" stamp.

5. Staff is using injection site codes that are not universally recognized and do not have a code listing in the chart.

6. The nurses' notes lacked specific times as to when they charted and when the event occurred.

7. The weekly summaries in the nurses' notes were lacking detail and in many instances were missing entirely.

8. The medication administration records lack signatures for many of the nurses' initials.

9. PRN medications given frequently lacked a documented reason for giving the medication and lacked a documented result of the medication administration.

10. The resident in room 5B has gangrene of the toes on his left foot and needs a foot cradle on his bed.

Environmental

11. There was a dirty glove found in the parking lot of the facility.

12. Upon entering the facility the team noted a moderate odor of urine that was noticeable throughout the facility.

13. There is no weatherstripping on the front door, leaving wide gaps for flying insects to enter the facility.

14. There was a vacuum cleaner in the hallway plugged in and left unattended, creating an ambulation hazard.

15. There was a coin operated candy/nuts dispenser in the TV room which allows residents on specialized diets unsupervised access.

16. There is no screen on the sliding door in the dining room, and the door is frequently left open for air circulation.

17. There was undated and uncovered food in the kitchen refrigerator.

18. The door to the dry goods storage does not close properly.

19. The exterior door to the kitchen does not close properly.

20. The door to the beauty shop was found to be unlocked, unattended, and there were chemicals inside.

21. The file cabinet in the rehab room was found to be open and the room unlocked and unattended, allowing unauthorized access to residents records of treatment.

22. The janitorial supply closet outside the kitchen was unlocked, unattended, and contained chemicals.

23. There were multiple bent, torn and off-track window screens. There were sliding door screens that were frequently left open, allowing flies into the facility.

24. There was eave damage noted on the north side of the building.

25. There are drain holes on the north side of the building that are not covered over and could be a hazard to residents and staff.

26. There is extensive stucco damage to the exterior of the facility.

27. The generator venting pipe has a hole in it.

28. The hallway handrails were sticky, possibly from a buildup of cleaning solutions.

29. The hallways had carts and wheelchairs along both sides of the hallway blocking clear pathways in case of an emergency.

30. There were no alarms on exterior doors. This is a hazard to wandering residents.

31. There is extensive water damage to the floor and tile on the north station.

Administrative

32. The personnel files lacked documentation of reference checks. The files only contain a checkmark with no information or date of contact.

Staffing

Below minimum daily requirements.

Fire

a. Fire extinguisher needs servicing.

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INSPECTION REPORT SUMMARY #44

Don Perry, Administrator
Fallbrook Hospital District SNF
325 Potter Avenue
Fallbrook, CA 92028

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Fallbrook Skilled Nursing Facility, located in Fallbrook, on October 17, 2001. The team identified the following issues:

Care Issues

1. The weekly nurses' notes are only being done once a month per shift.

2. The nurses' notes lacked detail and in many instances were missing entirely. Incidents were not documented as being followed up, descriptions of injuries and bruising lacked proper measurements and color descriptions.

3. The medication administration records lacked signatures for many of the nurses' initials.

4. PRN medications given frequently lacked a documented reason for giving the medication and lacked a documented result of the medication administration.

5. Some annual history and physicals are not up to date in residents medical records. They also lacked an interval history and complete physical findings.

6. Some residents were not being seen on a timely basis by the attending physician.

7. Weekly weights noted in the care plans were not documented as done.

8. MDS form, assessments and resident's care plans do not appropriately reflect the current status of the resident.

9. Some physicians are not signing their progress notes, which are illegible, uninformative, and lacked evidence of a physical examination for which Medi-Cal is paying.

Environmental

10. There is water damage to the eaves on the north corner of the building.

11. There are multiple window and sliding door screens that are bent, torn, missing or off-track, allowing flies into the facility.

12. The north side gate was found to be open, despite a sign stating "keep closed."

13. There was a ladder propped against the side of the building leading to the roof that had been left unattended, creating a potential hazard for wandering residents.

14. The sprinklers' system has not been inspected since 1993, and must be done every five years.

15. The detached storage shed was found unlocked, and it contained chemicals.

16. There was a wasp nest under the eaves on the west side of the building.

17. The front door to the facility does not close properly.

18. The handrail between room 7 and the linen closet is loose.

19. There were several items in both the walk-in refrigerator and the smaller refrigerator in the kitchen which were not properly covered and dated.

20. The shower room next to room 40 has a badly rusted door frame.

21. There was germicidal spray left in the shower room next to room 24.

22. All oxygen tanks were not properly secured in the oxygen closet.

23. Most exterior doors lacked weatherstripping and had wide gaps between the door and the frame, allowing easy access to flies.

Administrative

No problems detected.

Staffing

No problems were detected

Fire

No violations.

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INSPECTION REPORT SUMMARY #45

Cynthia Lagatuz, Administrator
Lakeshore Convalescent Hospital
1901 Third Ave.
Oakland, CA 94606

Number of beds: 38

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Lakeshore Convalescent Hospital, located in Oakland, on October 24, 2001. The team identified the following issues which were discussed during our exit meeting:

Care Issues

1. The residents of Dr. M. who have had abnormal lab results have no evidence of follow up lab work being done.

2. Dr. M. is also using a large number of psychotropic drugs on his patients. You need to have your pharmacy consultant check for drug interactions.

3. The medication administration records lack some signatures for many of the nurses' initials.

4. Some PRN medications given frequently lacked a documented reason for giving the medication and lacked a documented result of the medication administration.

5. At 8:00 a.m. the medicine room was found to be unlocked and unattended.

6. There was food in the medication refrigerator next to medications.

7. Residents complained that staff becomes noisy at about 5:00 a.m. and need to be reminded that residents are still sleeping.

Environmental

8. There were several window and sliding door screens which were torn, bent and/or off-track, which allows flies access to the facility when the doors and windows are left open.

9. The patio door next to the nurses' station was open when we entered the facility and was left open for more than 20 minutes.

10. The scoop for the ice machine was left in a plastic container, and flies were noted sitting on it. A more sanitary method of storage is needed.

11. The facility has an apparent problem with moths. Several were found, both living and dead, in various parts of the facility.

12. There were no occupancy signs on the shower room doors. Staff was seen entering without knocking, and when we knocked on the door of one shower room the aide failed to answer. When I entered the room, the CNA was drying off a female resident. Failing to respond to a knock can be as embarrassing as failing to knock before entering.

13. The floor beneath the wooden slats in the linen closet is in need of cleaning.

14. Residents complained about the lack of closet separation for their clothing.

15. There was a leaking faucet in the hopper of the utility room.

16. The kitchen supply closet has boxes stacked to the ceiling, violating the required 18-inch clearance for fire safety.

Administrative

17. The personnel files lacked documentation of reference checks. Also, two of six files checked had no signed proof of elder abuse training.

18. There was nothing in the personnel files indicating that a DOJ check had been done per regulation.

Staffing

Below minimum daily requirements.

Fire

No problems were detected

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INSPECTION REPORT SUMMARY #46

Cheryl Cartney, Administrator
Grant Cuesta Nursing & Rehab
1949 Grant Road
Mountain View, CA 94040

Number of beds: 102

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Grant Cuesta Nursing & Rehabilitation, located in Mountain View, on October 25, 2001. The following are the issues noted by team and discussed with the administrative staff during the exit conference:

Care Issues

1. There were no occupancy signs on the shower room doors and staff was observed failing to knock before entering.

2. The wheelchair of resident [redacted] M. has torn arm pieces. She also complained that her lower dentures were missing.

3. Our chart review indicated that many of the updated H&P's lacked an interim history. Two of ten files lacked a completed up-to-date history and physical form.

4. Resident M. lacks up-to-date lab work especially an albumin level. She has also had a recent weight loss and there is a lack of consistent food intake documentation.

5. Resident H. has lab work results indicating anemia, but she remains on Advil, which is known to have a side effect of anemia.

Environmental

6. There were several bent and/or off track window screens noted which could allow flying insects into the facility.

7. The benches around the flower beds on the patio are in need of sanding and repainting.

8. There were numerous safety hazards noted in the area on the east side of the building, such as a stack of boards with nails and screws sticking up, paint cans lying around, and "junk" piled up.

9. All exit doors need to be checked for gaps which allow flying insects into the facility, worn weather stripping, and misalignment. Most also lack any alarms and lead outside the facility.

10. There was an extension cord being used for the television in 34.

11. The treatment cart at Station 2 was found to be unlocked and unattended.

12. Two of the hallways were blocked by carts and wheelchairs on both sides.

13. The enteral supply room on station two was found to be unlocked and containing medications and syringes.

14. The housekeeping office was found to be unlocked and unattended, and contained cleaning chemicals, including highly toxic road cleaning solvent.

15. The team found both snack and drink vending machines on the residents' patio providing unsupervised access by residents who may have dietary or swallowing problems.

16. The activity room door leading outside, and to a busy street, was found to be both unlocked and unalarmed, presenting a danger to residents who might wander out.

Administrative

No problems were detected.

Staffing

Below minimum daily requirements.

Fire

a. A full service inspection and testing of the fire alarm system shall be conducted annually by a state licensed contractor.

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INSPECTION REPORT SUMMARY #47

Bruce Udelf, Administrator
Villa Gardens Health Care Unit
842 East Villa St.
Pasadena, California 91101

Number of beds: 54

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Villa Gardens Health Care Unit, located in Pasadena, on October 31, 2001. The following issues were noted by the team and discussed with the facility administrative staff during our exit meeting.

Care Issues

1. Overall the medical records were adequate, but the nurses' notes on some entries lacked specific times.

2. It was also noted that overall the BUN and creatinine levels in the charts reviewed were elevated, indicating that some residents are under-hydrated.

Environmental

3. There was a window screen missing on the east side of the facility and two bent screens; one on the east and one on the south side of the building.

4. The gate on the east side of the building does not lock or close properly.

5. The exterior door to the kitchen was propped open with a towel and lacked a screen.

6. There was a used glove found in the specimen refrigerator in the utility room.

7. There was feces noted on the floor in the back shower room.

8. The storage room near the southwest exit has a hole in the corner.

9. The mechanical room was found to be unlocked and could be a hazard to residents.

10. The employee lounge door was left open and contains a vending machine which could provide unsupervised access to residents with high sugar and sodium snack restricted diets.

11. There were no occupancy signs on shower room doors which could create a privacy issue for residents.

12. There was food in the medication refrigerator in the med room.

13. There was uncovered and undated food in the kitchen refrigerator.

14. The therapy room was found to be open and unoccupied at 7:30 am, and it contained an operating, hot hydroculator which could be a hazard to residents when left unsupervised.

15. The floors in the clean linen closet needed cleaning.

Administrative

16. The personnel file of [redacted] E., CNA, lacked an updated certification in either the file or the certification binder.

Staffing

Below minimum daily requirements.

Fire

Unavailable.

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INSPECTION REPORT SUMMARY #48

Rodger Groves, Administrator
South Pasadena Convalescent Hospital
904 Mission Street
South Pasadena, CA 91030

Number of beds: 156

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise revisit of South Pasadena Convalescent Hospital, located in South Pasadena, on October 31, 2001. The following areas of concern were noted by the team:

Care Issues

No problems were detected

Environmental

1. There were two bent screens on residents windows. The screen in room 103 does not fit the window properly, three flies were noted in the room and the resident in bed one is totally dependent for care and already has two open areas to attract flies.

2. The exterior doors of the facility lacked weather stripping between the doors allowing insects access into the facility.

3. The brick fence between the facility and the adjoining property still has a large crack and a capper brick which is no longer set in place.

4. Vending machines were located in the patient dining rooms, which could cause a potential danger by creating a situation of unsupervised access to the vending machine by residents with choking problems, as well as, those on diabetic, low

sodium, or calorie restricted diets.

5. In the kitchen there was covered but unlabeled food in the refrigerator, and the refrigerator door had been left unlatched.

6. Residents only complaint was that it is sometimes a little noisy at night.

Administrative

No problems were detected

Staffing

No problems were detected

Fire

Not applicable

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State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
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Personal (916) 263-0809

INSPECTION REPORT SUMMARY #49

Mary Perez, Administrator
Studio City Convalescent Hospital
11429 Ventura Blvd.
Studio City, CA 91604

Number of beds: 181

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Studio City Convalescent Hospital, located in Los Angeles, on November 1, 2001. The following were issues noted by the team and discussed with the facility staff during our exit meeting:

Care Issues

1. Several residents lacked name bands, which is a potential danger for wandering residents and for registry or new personnel passing medications.

2. It was noted that the call light for room 16 was on for more than nine minutes, while several staff including licensed personnel walked past the room.

3. Resident interviews indicated residents would like to see the housekeeping staff keep the facility cleaner.

4. The residents complained about poor response to call lights at night.

Environmental

5. There were numerous bent and/or off-track window and door screens throughout the facility.

6. One window screen on the east side is off track and the window does not close due to a strip of cardboard placed to hold up the window. This allows flies access to the inside of the facility where they can lay eggs in the many open wounds of the residents.

7. The patio door leading to Ventura Blvd. was not secured.

8. The exit doors to most of the patio areas do not close properly.

9. The west side gate was open and leads to the west walkway which leads to the river canal, and to the basement storage area which was open and contains chemicals and large equipment.

10. In the kitchen there were items that were not properly labeled, including two plastic storage containers which were not closed properly and were not labeled.

11. In the laundry room one of the washing machines was leaking.

12. The concrete of the walkways is broken and uneven in some places.

13. The exterior doors lack weatherstripping and have large gaps which allow flying insects into the facility.

14. The shower rooms lack occupancy signs and the staff fails to knock on the door before entering. This is a potential privacy issue for the residents.

15. There was a moderate odor of urine in the facility when the team entered, which increased toward the back of the facility.

16. The elevator leading to the lower floors is unsecured and is located in an unobservable area of the facility. Residents could wander onto the elevators without being noticed.

17. The medication room door for Station three and four was left open and unattended.

Administrative

18. One resident complained that a CNA named A[redacted], on the 11 to 7 shift, has been rude. One time the resident asked for help and the CNA said, "I'm not here to get anything for you. I'm not your CNA." Another time the resident complimented the CNA on how she looked and was told, "I don't give a shit how I look. I'm just here to work."

Staffing

Below minimum daily requirements.

Fire

a. Repair fire assembly doors (by Nurses station 3, by Rec Room, Hall by laundry, hall by room #34) to close and latch.

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INSPECTION REPORT SUMMARY #50

Marlene Robertson, Administrator
Golden Cross Health Care of Fresno
1233 A Street
Fresno, CA 93706

Number of beds: 80

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Fresno County team conducted a surprise revisit to Golden Cross Health Care of Fresno, located in Fresno, on November 13, 2001. The following areas of concern were noted by the team, many of which had been noted during the inspection on March 20, 2001:

Care Issues

1. Residents are still being observed in their rooms with the doors open, no curtains drawn, wearing only an open backed gown and no underwear. This exposes both the resident and anyone passing by to possible dignity issues.

2. There were no occupancy designations on the shower rooms. We observed staff going in and out of the shower rooms without knocking, exposing the residents to dignity issues.

3. The resident in room 16 still appears to be smoking in his room as there appeared to be an odor of cigarette smoke present.

4. Residents complained about the food being cold and their doctor never spending any time with them other than a brief wave as he passes by the rooms.

5. One resident was observed by a team member to drop an eating utensil. A staff person picked it up off the floor and gave it back to the resident to continue eating his lunch. The team member had to step in and request a clean utensil for the

resident.

Environmental

6. There were still screens on several windows which were bent or off track. There were several flies noted throughout the facility.

7. The roof is in need of repair in many areas. There are missing roof slats missing, bulging, or rotting from the moss overgrowth.

8. There was a very strong odor of urine and feces throughout the facility.

9. Many handrails are in need of sanding and refinishing.

10. There still is wall and floor damage noted throughout the facility.

11. Vending machines were located in resident accessible areas. This could cause a potential danger by creating a situation of unsupervised access to the vending machine by residents with choking problems, as well as, those on diabetic, low sodium, or calorie restricted diets.

12. The gasket on one of the refrigerators is cracked and not sealing properly.

13. There was food in the refrigerator that was unlabeled and undated.

14. There was ceiling damage from a roof leak noted in the diningroom. There appeared to have been an attempt at patching the leak, but additional water apparently leaked around the patch work.

15. There was an exposed screw near the toilet handrail in the bathroom in room 36.

16. There was a key in the lock of the door to the utility room, despite a large, posted sign on the door instructing employees not to leave the key in the lock.

17. There still is some wall damage in the laundry room.

18. The resident's rooms lack any homelike personal touches and look institutional.

Administrative

No problems were detected.

Staffing

No problems were detected

Fire

Not applicable.

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INSPECTION REPORT SUMMARY #51

Michael Fellen, Administrator
Sunnyside Convalescent Hospital
2939 S. Peach Avenue
Fresno, CA 93725

Number of beds: 116

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Sunnyside Convalescent Hospital, located in Fresno, on November 14, 2001. The team identified the following issues:

Care Issues

1. In the Sun room it was noted that the television was on and there were several residents in the room, but they were all turned away from the television. Three staff were also present and none were interacting with the residents. This remained the case on all three occasions when the team checked the room.

2. There were multiple geri-chairs and wheelchairs that had torn seats, backs and armrests, which could damage residents fragile skin.

3. The nurses' notes were lacking detail and in many instances were missing entirely. Incidents were not documented as being followed up. Descriptions of injuries and bruising lacked proper measurements and color descriptions.

4. The medication administration records lack signatures for many of the nurses' initials.

5. PRN medications given frequently lacked a documented reason for giving the medication and lacked a documented result of the medication administration.

6. Residents bowel records indicated no bowel movements for some residents for

several days, but PRN laxatives were not given as ordered.

7. Some annual history and physicals are not up to date in residents medical records. They also lacked an interval history and complete physical findings.

8. Residents were not being seen on a timely basis by the attending physician.

9. MDS form, assessments and resident's care plans do not appropriately reflect the current status of the resident.

Environmental

10. There were multiple windows and doors on the facility which had screens which were bent, torn, missing or off-track. This allows flies into the facility when windows and sliding doors are left open.

11. The drinking fountain in building 2 was very dirty.

12. The utility room in building 2 was missing the fan/vent cover.

13. In building 1 there were several broken and missing tiles in the shower room.

14. There were multiple flies noted in both buildings.

15. The dryers in the laundry are badly in need of cleaning.

16. There is a long-standing leak in one of the washing machines in the laundry room.

17. The kitchen floor is badly in need of thorough cleaning, including the pantry and behind doors.

18. In the kitchen pantry were two bags of buns and a bag of macaroni left open and unlabeled. Some were very stale. This attracts rodents and insects.

19. The shower room across from room 9 is missing a substantial amount of grout.

20. In the north building there were multiple wheelchairs blocking the emergency exit.

21. There was a razor left out in room 204, which is hazardous to wandering residents.

22. The utility room was found to be unlocked and unattended, and contained chemicals.

23. In room 6 there was an open bottle of sterile water which was not dated.

24. In building 1 there was food in the medication refrigerator next to the medication.

Administrative

25. Personnel files lacked documentation of reference checks.

26. The CNA certification for [redacted] J. expired 1/18/00, and there is no updated certification in the file and no documentation of a check by the staff.

27. Several items listed on the residents personal inventory records were found in the residents room, but were not properly labeled.

Staffing

28. Staffing was well below the required 3.2 hours per patient day.

Fire

No violations were detected.

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INSPECTION REPORT SUMMARY #52

Jewell Williams, Administrator
Raintree Convalescent Hospital
5265 E. Huntington Ave.
Fresno, CA 93727

Number of beds: 49

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Raintree Convalescent Hospital, located in Fresno, on November 15, 2001. The team observed the following issues and discussed them with the administrative staff during the exit meeting.

Care Issues

1. The medication cart was found to be unlocked in the hallway near the nurses station at 7:50 am.

2. The medical records revealed a lack of continued assessment and re-assessment of residents at risk for falls. The nurses notes showed good documentation of the falls, but the care plans and assessment forms lacked proper documentation of follow-up of changes to the plans.

3. There was a vending machine noted on the patio, an area which allows unsupervised access to sugar and salt by residents on restricted diets. This could be a potential hazard to the health and welfare of the residents.

4. At 8:00 am it was noted that the CNA's feeding residents in the diningroom were feeding the residents very quickly rather than at the residents own pace, which could lead to choking, and were not interacting in any way with the residents.

Environmental

5. It was noted at 7:45 am that the residents room floors were in need of cleaning.

6. Some handrails were sticky to the touch.

7. There was wall damage to the corner outside the office of the diet supervisor.

8. There were no occupancy signs on any of the shower rooms and no signs reminding staff to knock before entering. This could cause a privacy issue for residents.

9. There was a moderate odor of stale urine and housecleaning solutions throughout the facility when the team entered.

10. There were several flies noted throughout the facility.

11. The utility room was found to be very messy and the hopper was dirty.

12. There were large gaps under the exterior doors of the facility and no weatherstripping. This is likely the main entry point of the flies.

13. The garden hose in the front of the facility was not properly stored and ccould be a hazard to residents walking in the area.

14. There was one moderately bent screen on a facility window.

15. There was considerable equipment and "junk" being stored in uncovered areas outside the facility. This included an area directly adjacent to the building, causing a possible fire hazard.

16. Extension cords were noted in the business office and in the maintenance building.

Administrative

17. Review of the personnel files showed a lack of documentation regarding reference checks.

18. One personnel file of a CNA showed an expired certification and no evidence of current certification verification.

Staffing

No problems were detected**.**

Fire

a. Remove the door stops on the corridor rated fire doors on the Staff Development Office and Dining Room.

b. Remove the exposed wiring on the ceiling behind the exit sign near room 8.

c. Change the sprinkler heads above the stove annually.

d. Seal the penetrations in the ceiling in furnace room one with approved fire caulk.

e. Discontinue use of the extension cord in the business office and the maintenance office.

f. Remove the combustible exterior storage away from the main building.

g. Plug the dryers directly into outlets and discontinue plugging them into a multi-plug adapter.

h. Discontinue use of the plastic gas can in the maintenance room. Provide listed and approved safety cans for storage and dispensing of flammable liquids.

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INSPECTION REPORT SUMMARY #53

Milton Wheeler, Administrator
Subacute/Saratoga
13425 Sousa Lane
Saratoga, CA 95070

Number of beds: 36

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Santa Clara County team conducted a surprise revisit to Subacute Saratoga, located in Saratoga, on November 19, 2001. Although the facility had improved, indicating that our concerns of May 9, 2001 were taken seriously by the administration, there were still some areas of concern noted by the team.

Care Issues

There were no issues detected.

Environmental

1. There was lighter fluid found by the outdoor BBQ.

2. The laundry room storage closet, inside the laundry room, contained chemical substances and was left unlocked.

3. There was floor damage noted by the washing machines in the laundry room.

4. The housekeeping room located by the laundry room still contained chemical substances and was unsecured.

5. There were snack and soda machines located in the front activity room, which were considered a potential hazard by the team. These allow unsupervised access to the machines by persons on restricted diets.

6. There was a large gap noted between the front doors which would allow insects into the facility.

7. There were several uneven concrete blocks noted in the back walkways. This could be a potential hazards for wandering residents or visitors.

Administrative

8. The resident's rights and various other policies which were posted in the lobby glass case were secured on top of each other, making it impossible for residents or their family to read it.

Staffing

No problems were detected

Fire

Not applicable.

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INSPECTION REPORT SUMMARY #54

Hung Chee Chan, Administrator
Empress Convalescent Hospital
1299 S. Bascom Avenue
San Jose, CA 95128

Number of beds: 67

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise revisit of Empress Convalescent Hospital, located in San Jose, on November 19, 2001. The team was pleased to observe that the previously identified issues had been taken seriously by the facility staff. The issues were no longer observed by the team. There were some new issues noted and we are confident that they too will be addressed by the administration:

Care Issues

1. Review of the medical records revealed that staff is failing to properly initial treatments on the treatment sheets, indicating that the treatments are not being done as ordered.

Environmental

2. There was a moderate odor of urine noted when the team entered the facility at 1:00 p.m.

3. The rain gutters are in need of cleaning as they are clogged with leaves.

4. The public phone was not working.

5. The shower room occupancy room signs are not being appropriately used by the staff.

6. There was a buildup of mildew beginning in the shower room by room 115.

Administrative

No problems were detected

Staffing

No problems were detected

Fire

Not applicable.

BMFEA
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State of California Department of Justice

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INSPECTION REPORT SUMMARy #55

Stephen Hooker, Administrator
West Valley Rehabilitation Center
16412 Los Gatos Blvd.
Los Gatos, CA 95030

Number of beds: 148

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On November 20, 2001, the Operation Guardians team conducted a surprise inspection of West Valley Rehabilitation Center, located at 16412 Los Gatos Blvd., in Los Gatos, California The following issues were noted by the team and discussed with the administration during the exit meeting:

Care Issues

1. Several residents complained about the staff being too noisy at night.

2. There were several complaints about a CNA named "D[redacted]" who is rude, and "not a very nice person".

3. There were several complaints about the food, particularly that it is not served hot.

4. There were complaints that the facility lacks activities directed at the younger residents.

Environmental

5. There were several bent, off-track and missing screens on windows and patio doors. This can allow flying insects into the facility.

6. The pantry room floor in the kitchen was very dirty. Several packages of bread were found to be open and not properly dated.

7. One half of the large refrigerator was found to be above the required temperature, and was rechecked multiple times during the survey.

8. There was a leaking washing machine in the laundry room.

9. There were used gloves found in several location near the delivery entrance.

10. There was a broken tile in the shower room floor of B108.

11. There were three soda vending machines located on the patio, allowing unsupervised access to items which may be disallowed on some residents diets.

12. There were items noted on both sides of the hallways which created an obstacle in case of a fire or other emergency.

13. The large storage area on the lower level, near the laundry room was left open. The room housed patients' financial records in an unsecured area.

14. Several soiled gloves were found on the floor across from room 318.

Administrative

15. Residents' personal inventory sheets were not up to date.

Staffing

No issues were detected**.**

Fire

a. Door to clean utility room, 2nd floor, must be closed.

b. Linen closet door, 2nd floor, must latch.

c. Remove excess storage from corridors.

d. Nursing staff doors must remain closed.

e. Adjust stair door to latch next to room 127.

f. Adjust B100 door to dining to latch.

g. Provide gasket one side linen room next to room 318.

h. Adjust door to latch room 327.

i. Gasket restroom door across from room 340.

j. Office next to payroll shall remain closed.

k. Provide gasket one side in Social Service office.

l. Adjust door to close and latch in room 348.

m. Replace bulb in exit light next to Dining Room, basement stairwell, and in main entrance.

n. Reduce storage to 18" below sprinklers in basement.

o. Provide cover plate and patch hole in basement next to Activity Director’s office.

p. Replace arm for closure on Med supply door next to room 346.

q. Replace arm in Janitor’s closet next to room 346.

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INSPECTION REPORT SUMMARY #56

James Kargol, Administrator
Holiday Manor Nursitarium
20554 Roscoe Drive
Canoga Park, CA 91306

Number of beds: 94

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Holiday Manor Nursitarium, located in Canoga Park, on December 11, 2001. The following issues were noted by the team and discussed with the administrator during the exit meeting.

Care Issues

1. There are no occupancy signs on the shower room doors. Although a team member knocked and waited before entering, there was no response. In the shower room was a CNA drying off a naked female.

2. The physicians' progress notes lacked physical findings and in many cases were illegible. This hampers continuity of care.

Environmental

3. There were broken tiles in the shower room on the north side.

4. The dirty linen carts stored in the shower room were overflowing. Cart lids did not fit properly and the odor was overwhelming.

5. There were multiple leaking faucets throughout the facility.

6. The exterior doors lack weatherstripping. This is allowing cold air and possibly insects in while letting warm air out.

7. The floor of the oxygen room was very dirty. This should be a clean area.There was a window screen from the Northeast corner of the facility which was found on the ground.

8. There were several empty Miller Beer cans found outside in the area by the emergency generator.

9. There was a moderate odor of urine in the hallways when the team entered the facility.

10. The hallway handrails are badly in need of sanding and refinishing as they are extremely rough and splintered and could cause injury to the residents' skin.

11. Some of your couches and chairs in the hallways have worn and damaged seats and backs and are in need of repair or replacement.

12. In the kitchen there was food in the freezer which was not properly covered and dated.

13. Dry goods in the kitchen pantry were not properly closed, including crackers and corn starch.

14. There were approximately six roaches of varying size, both living and dead, found on the floor of the kitchen.

15. Shower room 2 was found to be dirty with dirty linen and used gloves on the floor.

Administrative

16. Personnel files lacked results of staff TB testing.

17. Ombudsman signs were not found in the required locations.

18. Residents rights were not displayed as required.

19. Residents' property inventory sheets were missing or lacked updating. This is necessary to maintain the rights of the residents.

20. The family council minutes reviewed lacked documentation indicating that the families were allowed time to voice concerns.

Staffing

No issues were detected**.**

Fire

a. Remove all items that block, obstruct, or diminish the required width of exit by laundry room.

b. Repair fire assembly door #2 to close and latch.

c. Maintain electrical panel room free of any combustibles, rubbish, materials, or storage.

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INSPECTION REPORT SUMMARY #57

Ron Meyer, Administrator
Oceanview Convalescent Hospital
1340 15th Street
Santa Monica, CA 90404

Number of beds: 227

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise revisit of Oceanview Care and Rehabilitation, located in Santa Monica, on December 11, 2001. The team was extremely pleased to see that the issues previously identified had been addressed by the facility administration. The following issues were noted during the revisit:

Care Issues

No problems were detected

Environmental

1. The door frame of one of the shower rooms on the 3rd floor is rusted near the floor, but it appears that repairs are being made.

2. The shower room on the 3rd floor had used gloves left on the floor.

3. The shower rooms lack occupancy signs.

4. The kitchen was clean, but there was food in the refrigerator that was not properly dated.

5. The treatment carts on all floors were found to be unlocked. They contained needles, syringes and medicated ointments which could cause a danger to residents.

6. One oxygen tank on the 2nd floor was not properly chained.

Administrative

No problems were detected

Staffing

Below minimum daily requirements.

Fire

Not applicable

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INSPECTION REPORT SUMMARY #58

William Joseph, Administrator
Beverly Manor Convalescent Hospital
7940 Topanga Canyon Blvd.
Canoga Park, CA 91304

Number of beds: 145

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Beverly Manor Convalescent Hospital, located in Canoga Park, on December 12, 2001. The following issues were noted by the team and discussed with the administrative staff during the exit meeting:

Care Issues

1. A resident was noted to be improperly positioned to eat in bed, a possible choking hazard.

2. There was food in the medication refrigerator on station one.

3. Residents complained about the food not being served hot and about call lights that are slow in being answered.

4. Medication sheets lack signatures for the initials.

5. Physicians' order sheets had orders which were unclear as to dosage, time, and method of administration.

Environmental

6. There were some sliding door screens that were off track.

7. There were a large number of empty cardboard boxes stacked next to the building.

8. Several storage closets were over-stuffed with items blocking the sprinkler system.

9. The exterior doors are in need of weatherstripping to prevent entry of flying insects and loss of both heat and air conditioning.

10. There was an extension cord attached to a TV in room 52, not plugged into wall, which needs to be replaced by a power strip.

Administrative

11. Personnel files lacked documentation of reference checks.

12. Trust accounts must be in an interest bearing account.

Staffing

No problems were detected

Fire

a. Remove all items that block, obstruct, or diminish the required width of exit throughout the building.

b. No part of a stairway, weather interior or exterior, nor of a smoke-proof enclosure, hallway, corridor, vestibule, balcony, or bridge leading to a stairway or exit of any kind, shall be used in any way that will obstruct its use as an exit or that will present a fire hazard.

BEVERLY HEALTHCARE

January 23, 2002

Diana Boutin, Special Agent
Bureau of Medi-Cal Fraud and Elder Abuse
2025 Gateway Place, Suite 474
San Jose, CA 95110

RE: Operation Guardians inspection of Beverly Nursing and Rehabilitation Center, Canoga Park, on December 12, 2001

Dear Ms. Boutin:

This letter is to inform you that a Plan of Correction has been initiated to address all issues. All issues will be resolved in a timely matter. A quality improvement team has been formed to ensure that call lights are answered in a timely manner.

Beverly is continually striving to improve the quality of care to our residents. The Quality Assurance and Assessment Committee meets monthly to oversee the quality and effectiveness of facility operations and systems to meet the needs of our customers. Opportunities for improvement are discussed and development of effective and measurable action plans are put into place.

I am pleased your inspection of our facility was a pleasant experience. If you have any questions or concerns, please call me at (818) 347-3800.

Thank you.

Sincerely,

William Joseph
Executive Director

7940 Topanga Canyon Boulevard
Conoga Park, CA 91304
(818) 347-3800 • FAX (818) 346-3917

YOUR PATHWAY HOME

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

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INSPECTION REPORT SUMMARY #59

Maury VanDerHope, Administrator
Antelope Valley Healthcare Facility
44445 N. 15th Street West
Lancaster, CA 93534

Number of beds: 299

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Antelope Valley Healthcare, located in Lancaster, on January 3, 2002. The team observed the following issues during the inspection, most of which were discussed at the exit meeting:

Care Issues

1. Multiple residents were observed being taken to the bathrooms and/or nearby shower rooms without being properly covered.

2. Residents were found to be sitting up in bed with trays of uncovered food in front of them while they slept.

3. Residents were found to be slumped over and partially elevated after breakfast trays had been removed.

4. While at one nurses' station it was noted that the door to the medication room was left open and no one was in attendance.

5. Nurses' notes weekly summaries were lacking in detail and adequate descriptions.

6. There were several weights noted that showed a steady decline without the resident being on a weight loss program.

7. The charts of Dr. G. lacked many physician signatures on doctor's order sheets.

8. The medication records lacked signatures for the nurses' initials.

9. There were several complaints from residents about staff being very noisy at night, particularly during shift changes.

10. There were some complaints from residents about staff being slow to answer call lights.

Environmental

11. There were some bent, torn and/or off-track window screens on the facility.

12. There was an unattended wooden ladder propped against the side of the facility leading up to the roof.

13. The facility gutters needs to be cleaned out.

14. There was an odor of urine throughout the facility, probably caused by the fact that the lids to the dirty linen containers were not being replaced properly.

15. There was mildew noted in the corners of some of the shower rooms.

16. There were leaking faucets in the kitchen.

17. Dirty gloves were found on the floor of the laundry room.

18. The lid of the ice machine was found to be open on two separate occasions during the inspection.

19. Many geri-chairs were found to be in need of repair, particularly the torn armrests.

20. Dirty linen had been left on the floor of the shower room on station 5.

21. There were some complaints about the bathrooms being too cold. This was confirmed by the inspection team.

Administrative

22. The residents' rights posted in the lobby were too small to be easily readable, and the set of rights located within the facility proper consisted of several pages stapled on top of each other on a bulletin board.

23. Review of personnel files found that they were up to date and in good order with the exception of a lack of documentation regarding reference checks of potential staff.

24. Several residents complained about the food being served lukewarm or cool when it should be hot.

Staffing

No issues were detected.

Fire

a. Exit doors in the kitchen with double locking devices and dead bolt locks.

b. Compressed gas oxygen cylinders improperly secured and store.

c. Recessed fire extinguisher cabinets improperly labeled.

d. Exit doors in kitchen not clearly identifiable.

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INSPECTION REPORT SUMMARY #60

Janice Delano, Administrator
Mayflower Gardens Convalescent Hospital
6705 West Avenue M
Lancaster, CA 93536

Number of beds: 48

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Mayflower Gardens Convalescent Hospital, located in Lancaster, on January 4, 2002. The team identified the following issues which were discussed with the facility Director of Nurses during our exit meeting.

Care Issues

1. A review of the diet checks, done at 7:35 a.m., revealed that the Director of Staff Development had initialed that he had checked both the breakfast and lunch trays for today. Since lunch trays had not been served as yet this was not appropriate charting.

2. In reviewing the medical record of [redacted] D. there were some medication errors noted. Serzone order was originally written as 100 mg, but was recapped on the physician orders and on the medication sheets as 10 mg. The residents is being given 100 mg, indicating that the staff is not properly checking the drug and dose when they give the medication. A second medication, Synthroid is documented as 75 mg, instead of 75 mcg or .075 mg. Our physician consultant questioned the orders for Colace 250 mg BID, Dulcolax tab QD, and MOM 30 cc QOD. There is no documentation of this regimen being discussed by the nursing staff with the physician and care planned if there is an ongoing bowel problem.

Environmental

3. The exit doors are worn in some areas and need replacing to prevent cold air and flying insects from entering the facility.

4. There was a garden hose left out on one of the patio's which could be a hazard to residents, although they do have very limited access to this patio.

5. There was dirty linen, washcloths, left in some shower rooms that are shared by multiple residents.

Administrative

No problems detected.

Staffing

No problems were detected

Fire

a. Remove or render inoperable the Dead bolt lock on emergency Exit door leading into the dining room.

MAYFLOWER GARDENS CONVALESCENT HOSPITAL
6705 W. AVE. M
QUARTZ HILL, CA. 93536
(661) 943-3212 FAX (661) 943-1303

January 22, 2002

BMFEA
Special Agent Diana Boutin
Operation Guardians
2025 Gateway Place, Suite 474
San Jose, Ca. 95110

Dear Special Agent Boutin,

This letter is to notify Operation Guardians that corrective actions have been initiated to correct the issues identified at the time of your surprise visit to Mayflower Gardens Convalescent Hospital on
January 4, 2002. The issues were addressed as follows:

1. The worn areas on exit doors have been replaced. Facilities Maintenance Supervisor will check doors quarterly and repair as needed to prevent cold air and flying insects from entering facility.

2. The garden hose was removed and will be stored away from resident access. Hose will be brought out when needed and after use will be returned to stored area.

3. The washcloths left in the shower rooms were immediately removed. Morning rounds will be made by Licensed Staff.

4. Meal trays will continue to be checked before each meal by a Licensed Staff member and initialed for that time only. Director of Nurses will make random checks of initials.

5. Both the Serzone and Synthroid orders have been corrected. The residents bowel problem was previously care planned dated 5/19/01. To prevent reoccurrence, Director of Nurses will ensure a three way check is in place at time of cycle fill to correct any recap errors.

Even though you stated a Plan of Correction is not necessary, please accept the above as our allegation of compliance.

Sincerely,

Janice Delano
Administrator

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INSPECTION REPORT SUMMARY #61

Chris Geyer, Administrator
Sierra Vista Nursing & Rehab Center
705 Trancas Street
Napa, California 94558

Number of beds: 120

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On January 8, 2002, the Operation Guardians team conducted a surprise inspection of Sierra Vista Nursing and Rehabilitation Center, located in Napa, California. The team identified the following issues which were discussed with the facility Administrator and the Director of Nurses during our exit meeting:

Care Issues

1. In the medical records it was noted that Dr. K. is not making monthly visits to his patients, with as much as three months passing between some visits. He is also not doing an annual history and physical on all of his patients.

2. Residents complained about staff being too noisy.

3. Residents complained about food not being served hot.

4. Resident [redacted] F. was noted to have a very dry mouth and had not received mouth care by 10:30 a.m. on the inspection day.

5. Resident [redacted] C. has no armband and the armrest of her wheelchair is torn. Her skin is very fragile and she already has numerous bruises and a skin tear on her hands.

6. Several female residents were noted to be wearing no underwear. The arms of the chair in room 30 have gouged and rough surfaces.

7. Resident [redacted] P.'s breakfast tray was found to be untouched at 9:25 a.m. The food had been left uncovered and was cold.

Environmental

8. The weatherstripping on the exit doors are worn in some areas and need replacing to prevent cold air and flying insects from entering the facility.

9. There were some window screens that were bent sufficiently to allow flies into the facility. There were also four patio door screens that were torn.

10. There were two garden hoses left out on one of the patio's that could be a hazard to residents.

11. There was a mud (insect?) nest on a window frame on the northeast corner of the building.

12. There was a cracked window on the east side of the building that was being held in place by masking tape.

13. Some patio and exit doors don't close properly.

14. The door to the maintenance room was found to be open and unattended. The room contained heavy tools and equipment.

15. There were large containers of laundry detergent and a partially full container of corrosive rust remover outside the door of the laundry room.

16. There were soda vending machines located in an unsupervised area on the center patio. This could present a danger to residents on special diets such as diabetic and low sodium.

17. The ice machine is located outside and the scoop for the ice was found to be in an uncovered plastic container sitting on a nearby table. This allows for easy contamination.

18. There was dirty linen and used gloves left on the floor in some shower rooms.

19. There was mildew beginning to grow in three of the shower rooms. There was also mold and mildew growing around one of the toilets in the shower room.

20. Two door frames to the shower rooms are rusted near the floor.

21. There was dirty underwear left on top of a dirty linen canister in Bath #1.

22. There is a badly leaking pipe under the sink in the kitchen. The faucet at that

same sink is also leaking.

23. There was a large bowl of tuna salad in the refrigerator that was not properly covered, and the bowl also contained a large spoon.

24. There were small dishes of dessert in the walk-in refrigerator that were not properly dated. There were glasses of milk and juice in the same refrigerator that were left uncovered..

25. The dietary supervisor was working in food preparation areas without a hairnet.

26. There was a small empty unsecured oxygen canister that was left on the floor of the west utility room. There were two small full canisters in the oxygen closet that were not properly secured.

27. There were food and medication together in the east medication room refrigerator.

28. There were extension cords being used in rooms 55, 61, and 63.

29. Dirty gloves were found on the floor in various rooms near the wastebaskets.

Administrative

No issues were detected.

Staffing

Below minimum daily requirements.

Fire

a. Provide a type K fire extinguisher.

b. Repair damaged light fixture.

c. Maintain 30" clearance in boiler room.

d. Repair/replace panic hardware at southeast end.

e. Maintain operable exit doors at the west and south ends.

f. Label the doors leading to kitchen and janitor’s room.

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INSPECTION REPORT SUMMARY #62

Andy Levin, Administrator
Napa Nursing Center
3275 Villa Lane
Napa, CA 94558

Number of beds: 130

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Napa Nursing Center, located in Napa, on January 9, 2002. The team identified the following issues which were discussed with the facility Administrator and Director of Nurses during our exit meeting.

Care Issues

1. The treatment carts on both Station 1 and 3 were left unlocked and unattended and contained medicated ointments.

2. There was food and medication together in the medicine room refrigerators on all three nurses stations.

3. Resident interview resulted in complaints about the food not being served hot and the majority of those interviewed do not like the food.

4. Residents also complained about the staff being noisy at night.

5. Medical records showed a lack of adequate descriptions and details in the nurses notes.

6. Dr. K. is not visiting his residents on a monthly basis, with as much as four months noted between progress notes, which were also poor.

7. The medical administration records lack signatures for the initials of the nurses.

8. The medical administration records also lack explanations for withheld and/or refused medications.

9. The in-service records have multiple discrepancies regarding dates and signatures.

Environmental

10. The gutters are beginning to rust on the northwest side of the building.

11. There was a garden hose left out on the walkway on the side of the building.

12. The gutter drain on the patio by Station 3 has fallen off the gutter.

13. There were bent and off track screens on multiple windows.

14. The patio door near Station 1 does not close properly.

15. There is a pile of trash composed of concrete, heavy wire and rusted pipe located by the side of the building that creates a hazardous condition for wandering residents.

16. The ground near the south side water main is eroding causing a possible hazard.

17. The hallway handrails are in need of sanding and refinishing as they are gouged and chipped in several places.

18. Several of the soiled linen containers did not have the lids on properly.

19. The Station 1 utility room had a very foul odor emanating from it.

20. The Station 1 utility room had a 2"x4" hole in the wall.

21. The shower room occupancy signs are not being utilized by the staff.

22. There was soiled linen left in two of the shower rooms.

23. Some of the shower rooms are caked with dirt or mildew in the corners and along the joint line at the floor.

24. There were spiders and webs noted in the north end hallway.

25. There was clean folded linen lying on the floor by the Station 1 nurses station.

26. There were tools, including a dirty shovel, left in the resident area near Station 1.

27. There were extension cords being used to connect Christmas decorations in room 222.

28. In the kitchen there was uncovered and undated food in the freezers and refrigerators. One of the freezers had spilled ice cream inside and was badly in need of cleaning.

29. There was a hole in the wall of the kitchen under the dishwashing sink, with an electrical box dangling out of the hole.

30. Oxygen tanks in both closets were not secured properly.

31. The staff lounge door was propped open during the first three hours of the inspection despite the “Keep door closed at all times” sign. Inside the facility were both soda and snack vending machines which allow unsupervised access to residents on specialized diets.

Administrative

32. Name bands are missing on 70% of the residents checked (more than 20). This is extremely hazardous, especially when registry personnel are passing medications.

Staffing

Below minimum daily requirements.

Fire

a. Provide Type K fire extinguishers at south east end.

b. Maintain 30" Clearance/Electrical Panel

c. Oxygen needs securing.

d. Housekeeping needs cleaning.

e. Repairs needed in kitchen.

f. Maintain operable exit doors.

g. Emergency generator failed.

h. Label the boiler room door and clean vents.

i. Blocked fire doors.

j. Maintenance area needs cleaning.

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INSPECTION REPORT SUMMARY #63

Steven Rule, Administrator
London House
678 Second Street West
Sonoma, California, 95476

Number of beds: 83

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On January 10, 2002, the Operation Guardians team conducted a surprise inspection of London House Convalescent Hospital, located in Sonoma. The team identified the following issues which were discussed with the facility Administrator and Director of Nurses during our exit meeting.

Care Issues

1. Residents complained about staff being too noisy at night and that they are speaking languages other than English.

2. Residents stated that activities are designed for those residents with low level mental and physical ability. Some variety is needed to meet the needs of some higher functioning residents.

3. Staff was slow in answering call lights, taking up to five minutes to respond. Staff was observed walking by rooms with the call light on and not checking to see if the resident was in need of immediate attention.

4. Meal consumption percentages are not being consistently charted. Many meals are missing a percentage.

5. Generally the physicians' progress notes are poor, many with only one or two words, and they lack physical exam findings.

6. Annual resident history and physical updates are missing. Some were last done in 1995.

7. Physicians' orders are not being properly noted with the date, time and signature of the nurse noting the order.

Environmental

8. There was dirty linen left on the floor and shower chairs in some shower rooms. Also, there was dirty linen on the floors of the residents' rooms and bathrooms.

9. The exit doors' weatherstripping is worn in some areas and needs replacing to prevent cold air from escaping and flying insects from entering the facility.

10. There was a garden hose left out and not stored properly, which could be a hazard to residents.

11. There were several screens on the facility that were bent, torn or off-track, which could allow flying insects into the facility where they can lay eggs in wounds.

12. The walkway on the sides of the facility had several large cracks in it which need repair as they could be hazardous to residents walking with walkers or cause difficulty for wheelchair passage.

13. A dirty fork was left on a table in an area used by staff for their breaks.

14. There was excessive clutter noted outside the northwest end of the building.

15. There is a canopied swing noted outside on which the cushion is badly torn. This could cause skin tears etc. to the fragile skin of the residents.

16. The door handle on the sliding door at the northeast end of the building is broken. Another door nearby does not slide properly and is out of alignment.

17. There was green "mold?" growing in the utility room hopper. It is badly in need of cleaning.

18. There are no occupancy signs on the shower room doors and staff is failing to knock before entering. This could become a resident privacy issue.

19. The linen in some clean linen closets is piled too close to the sprinkler heads.

20. The light in one linen closet did not have a cover.

21. The housekeeping closet door was locked, but not closed properly and was left unattended.

22. The hallway handrails are in need of cleaning and/or refinishing.

23. In the kitchen there was an open loaf of bread that was not properly stored.

24. There were uncovered and undated bowls of ice cream in the freezer.

25. The gaskets of the freezers need replacing as they are badly worn.

26. The therapy room door was open and unattended when the team made their rounds at about 7:30 a.m.. There was a working stove and a hot hydroculator in the room which could cause injury to wandering residents.

Administrative

No problems were detected.

Staffing

No problems were detected.

Fire

There were no violations.

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INSPECTION REPORT SUMMARY #64

Grace Ku, Administrator
Courtyard Care Center
340 Northlake Drive
San Jose, CA

Number of beds: 76

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On January 22, 2002, the Operation Guardians team conducted a surprise revisit of Courtyard Care Center, in San Jose. The team was pleased to observe that the previously identified issues had been taken seriously by the facility staff. Most of the issues were no longer observed by the team. There were some issues noted as follows:

Care Issues

1. Some call lights were still not being answered in a timely manner. Staff was seen passing by call lights without looking in the room to check on the needs of the resident. This included licensed staff.

2. Nurses' signatures were missing for the initials on some of the medication administration records.

Environmental

3. There was some mildew beginning to build up in the back shower rooms.

4. There were a few bent and off-track window screens which could allow flies into the facility.

5. There was uncovered food, specifically Jell-O, in the kitchen refrigerator.

6. There was a mild odor of urine on the back hallways.

Administrative

No problems were detected

Staffing

Below minimum daily requirements.

Fire

Not applicable.

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INSPECTION REPORT SUMMARY #65

A.J. Cafferata, Administrator
Casa Olga Intermediate Care Facility
180 Hamilton Avenue
Palo Alto, CA 94301

Number of beds: 103

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Casa Olga Intermediate Care Facility, located in Palo Alto, on January 26, 2002. The team identified the following issues which were discussed with the facility Administrator and Director of Nurses during our exit meeting:

Care Issues

1. The monthly summaries in the nurses' notes lacked detail and in many instances were missing entirely.

2. The medication administration records lacked signatures for many of the nurses' initials.

3. PRN medications given frequently lacked a documented reason for giving the medication and lacked a documented result of the medication administration.

4. Annual history and physicals are not up to date in all residents medical records. [redacted] C. (Dr. S.) last H&P was done 11/2/00.

Environmental

5. The elevator inspection license in the elevator has an old expiration date.

6. There was food in the refrigerators that were uncovered and undated.

Administrative

7. The personnel files lack documentation of reference checks. They just have a checkmark with no information or date.

8. The personnel file of [redacted]C. lacked an up to date certification.

9. The residents' petty cash accounts, money taken from the trust accounts, lacked proper signatures and are under the control of more than one person.

10. The resident's rights are posted in only one area, by the nurses station on the second floor. I suggest they be posted on every floor in a prominent area, such as by the elevators.

Staffing

Below minimum daily requirements.
.

Fire

a. Remove chairs from the exit stairwell.

b. Rated doors in corridors are wedged open on floors two and three.

c. Floor control valves in the stairwell need locks on all floors.

d. Emergency lighting needed along an exterior exit path off 8th floor dining room. Also, keep this area clear of trip hazzards.

e. Emergency lighting and exit signs needed at West exit area of dining room.

f. Add more emergency lights to the main dining area.

g. Remove all storage in first floor maintenance area to below 18" under the sprinkler.

h. The door opening through a rated wall in maintenance room needs to be fire-resistive construction.

i. Obtain a building permit to change the use of a storage room to a laundry. The dryers need to be vented.

j. High storage in storage room adjacent to the garage.

k. Five year maintenance is needed on sprinkler system.

l. Alarm system appears to be inoperable at the riser due to corrosion at the battery.

m. Building alarm system needs maintenance.

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INSPECTION REPORT SUMMARY #66

Elizabeth Plott, Administrator
Orangetree Convalescent Hospital
4000 Harrison Street
Riverside, CA 92503

Number of beds: 146

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Orangetree Convalescent Hospital, located in Riverside, on January 24, 2002. The team identified the following issues which were discussed with the facility Assistant Administrator during our exit meeting:

Care Issues

No problems were detected.

Environmental

1. The lock to the generator room was locked but the door was left open and unattended.

2. There was a garden hose left out on the side of the building.

3. There was a leaking faucet noted in the kitchen and one in the women's shower room by room 121.

4. There was some bent and off track screens noted.

5. The lock to the sliding glass door in the dining room which leads to the patio is broken and needs repair. The facility had already noted this and was in the process of arranging its repair.

Administrative

No problems were detected

Staffing

No problems were detected

Fire

No violations were detected

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INSPECTION REPORT SUMMARY #67

Julie Bischoff, Administrator
Brookside Healthcare Center
105 Terracina Blvd.
Redlands, CA 92373

Number of beds: 97

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On February 5, 2002, the Operation Guardians team conducted a surprise inspection of Brookside Healthcare Center, located in Redlands. The team identified the following issues which were discussed with the facility administrative staff during our exit meeting:

Care Issues

1. Pharmacy consultant notes in the individual residents medical records were not present, and there was no documentation that the suggestions of the consultant were being followed up.

2. There were several instances of a lack of signatures for the nurses' initials on the medication administration records.

3. There was poor documentation of follow-up assessments and care planning for residents who had fallen.

4. One resident had suffered many falls due to seizures and there were head lacerations documented, but no Dilantin levels were found, and there was poor monitoring documentation of the seizure activity.

5. The residents care plans lacked clarification of medications, seizure monitoring and the monitoring of falls.

Environmental

6. The utility room by Station One had a very offensive odor emanating into the hall when the door was opened.

7. Several patio screens on sliding doors were not level, leaving wide gaps at the top or bottom, which allows flying insects into the facility. Also, the opening and closing of the screens was difficult due to the tracks being very dirty.

8. There were several flies noted in the facility hallways.

9. Several of the armrests on the geri-chairs were torn and could be a hazard for the fragile skin of your residents.

10. There were food items in the kitchen freezer which were not properly dated.

11. There were curtains lying across a hot hydroculator in the therapy room, which could become a fire hazard.

12. The maintenance office in the back of the facility contained tools and equipment and had been left unlocked and unattended.

13. The bio-hazardous waste container had been left unlocked and unattended.

14. There were no occupancy signs on shower room doors and staff was entering without knocking. This could become a breech of residents' privacy.

Administrative

No issues were detected.

Staffing

No issues were detected.

Fire

No violations.

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INSPECTION REPORT SUMMARY #68

Sue Fairley, Administrator
Plymouth Village Health Center
819 Salem Drive
Redlands, CA 92373

Number of beds: 48

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Plymouth Village Health Center located in Redlands, on February 6, 2002. The team identified the following issues which were discussed with the facility Director of Nurses during our exit meeting:

Care Issues

1. The medication administration records lacked nurses' signatures for their initials and the records were inconsistent in the documentation of the results of PRN medications administered.

2. Physicians were not signing the telephone order sheets in a timely manner.

3. There was a lack of physicians' signatures on some Preferred Incident of Treatment sheets.

4. The Director of Nurses, while changing a dressing, was observed failing to wash her hands between residents cared for and did not until she was asked to do so by the team member.

Environmental

5. There were oxygen canisters not properly secured in the oxygen closet.

6. The Staff Lounge door was propped open which allowed unsupervised access to

the vending machines by residents who are on specialized diets.

7. There was a bent window screen on the east side of the building.

8. There was a leaking faucet in the kitchen.

9. There were no occupancy signs on the shower room doors and staff was failing to knock on the doors. This could create a privacy issue for the residents.

Administrative

10. The head of the resident council is not capable of heading the meetings and the activity director has been conducting the meetings, which is contrary to regulation.

11. When the power failed in part of the facility, the emergency generator failed to turn on.

Staffing

No problems were detected

Fire

There were no violations.

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INSPECTION REPORT SUMMARY #69

Robert Bowersox, Administrator
Arden Rehabilitation & Health Care Center
3400 Alta Arden Expressway
Sacramento, CA 95825

Number of beds: 170

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On February 13, 2002, the Operation Guardians team conducted a revisit inspection of Arden Rehabilitation & Health Care Center, located in Sacramento. The team was pleased to note that many of the issues previously identified had been addressed by the facility. The following areas of concern were noted by the team during this visit and were discussed with you during our exit meeting:

Care Issues

1. The medication administration records lacked signatures for the nurses' initials in many instances.

2. Patient call lights were not being answered in a timely manner as observed by the team. Some calls lights went unanswered in excess of five minutes, and staff was observed passing the rooms without looking in to see if it was an immediate need.

3. Some residents still complained about food being served cold and that trays are left in the hallway on carts rather than being served right away.

4. There were still complaints about loud staff at night.

5. Nurses notes do not always accurately depict the condition of the resident, and assessment and care plans are not consistent.

6. The physicians' annual history and physical reports do not document an interval history on the resident and are incomplete.

Environmental

7. There was an odor of urine in the 300 hallway of the facility due to dirty linen carts not being covered properly.

8. In the kitchen there were some food items that were not properly dated. Some items in the refrigerator had dates as old as January.

9. At the rear of the facility, outside, there was a discarded refrigerator which had not been properly secured and could be a danger to any resident or child who crawled into it.

10. There was a large build up of trash in back of the facility building.

11. There were dirty gloves on the floor of the shower room by room 210. There was dirty linen left on the floor of the shower room across from room 214. There was a razor left in the shower room by room 306.

12. The hallway in the 300 wing was cluttered on both sides by wheelchairs and carts, blocking clear access in case of an emergency.

13. The key to the door of the utility room on the east station was left in the door. The utility room was extremely messy.

14. There was dirty linen left on the floor of the bathroom in room 111.

15. The shower room by room 510 was smeared with dried feces.

16. There was a dirty glove found on the floor of room 517.

17. There was floor damage across from the central supply room.

18. The rear central patio sliding door screen is badly bent and does not slide properly, causing staff and residents to leave it open allowing flies into the facility.

Administrative

19. One personnel file reviewed had an expiration date for the CNA certification of 11/24/2001. There were no updated information and no documentation that the certification had been checked by the facility staff.

Staffing

20. Staffing levels were noted to be below the required 3.2 hours per patient day on

several dates reviewed.

Fire

Not Applicable

ARDEN REHABILITATION
3400 Alta Arden Expressway, Sacramento, CA 95825
916-481-5500

June 17, 2002

Bureau of Medi-Cal Fraud & Elder Abuse
Special Agent Larry Menard
2025 Gateway Plaza, Suite 474
San Jose, CA 95110

RE: Arden Rehabilitation and Health Care Center

Dear Mr. Menard:

Enclosed you will find our follow-up plan for the issues noted in your on-site visit on February 13th. We are sorry this is late. We mistakenly believed that our reply to your March 28th letter was all that remained outstanding.

Thank you again for your positive comments and favorable findings. If there is anything else which would be helpful, please advise.

Sincerely.

Robert Bowersox
Administrator

Cc: Steve Keh

Arden Rehabilitation and Healthcare Center
Bureau of Medical Fraud and Elder Abuse

	Recommendation	Comment	Responsible Party	Completion Date
1	The medication administration records lacked signatures for the nurses initials in many instances	An audit will be conducted by Medical Records on the Medication Record (MAR) regarding nurse's initials.	Medical Record Designee	June 28,2002
		An in-service will be conducted by the Director of Nursing (DNS) regarding nurse's need to initial the medication record.	DNS	June 28,2002
2	There was an odor of urine in 300 hallway of the facility due to dirty linen carts not being covered properly.	An in-service will be completed by the Director of Staff Development regarding but not limited to: - Cleanliness - Infection Control - Linen barrels and carts	Director of Staff Development	June 28,2002
		Housekeeping Supervisor will provide an in-service with the housekeeping Staff regarding: - Cleanliness - Transporting dirty linen carts to laundry room	Housekeeping Designee	June 28,2002
3	Patient call lights are not being answered in a timely manner as observed by the team. Some call lights went unanswered in excess of five minutes, and staff was observed passing the rooms without looking in to see if it was an immediate need.	In-service will be conducted by the Director of Nursing Service to Licensed Nurses regarding Supervision of Unit and answering call light on a timely manner.	DNS	June 28,2002
		In-service to be conducted by the Director of Staff Development (DSD) regarding answering call lights in a timely manner.	DSD	June 28,2002
4	In the Kitchen there were some food items that were not properly dated. Some items in the refrigerator had dates as old as January.	Kitchen Supervisor will conduct an in-service to kitchen staff regarding but not limited to: - Food labeling and dating - Discarding old food	Kitchen Supervisor	June 28,2002
		Monthly inspection will be done by the Dietary Supervisor to ensure that kitchen items are properly labeled and dated.	Kitchen Supervisor	May 29,2002 Ongoing
5	Some residents complained about food being served cold and that trays are left in the hallway on carts rather than being served right away.	An in-service will be conducted by the Director of Staff development regarding serving meals to the residents in a timely manner.	DSD	June 28,2002

	Recommendation	Comment	Responsible Party	Completion Date
6	There were complaints about loud staff at night.	An in-service will be conducted by the Staff Development to the PM and NOC crew regarding but not limited to: - Noise level especially at NOC time - Dignity and respect to residents home	DSD	June 28,2002
7	One personnel file reviewed had an expiration date for the CNA certification of 11/24/01. There was no updated information and no documentation that the facility staff had checked the certification.	Director of Staff Development will review all CNA files to ensure that all certifications are current. A tickler file will be made by the DSD to monitor the expiration of licenses and certification of the staff.	DSD	May 29,2002
8	At the rear of the facility, outside, there was a discarded refrigerator which had not been properly secured and could be a danger to any resident or child who crawled into it	Maintenance Director will discard the refrigerator.	Maintenance Director	May-02
9	There was a build-up of trash in back of the facility building	This was temporary. The Maintenance Director was aware and the trash was removed.	Maintenance Director	May-02
10	There were dirty gloves on the floor of the shower room-by-room 210. There was dirty linen left on the floor of the shower room across from room 214. And there was a razor left in the shower room by room 306.	In-service will be conducted by the DSD to the C.N.A regarding but not limited to: - Disposal of gloves and sharps - Cleanliness of the shower and bedrooms.	DSD	June 28,2002
		In-service will be conducted by the Director of Nursing to the Licensed Staff regarding but not limited to: - Disposal of gloves and sharps - Cleanliness of the shower and bedrooms. - Supervision of Nurse Assistants	DNS	June 28,2002
11	The hallway in the 300 wing is cluttered on both sides by wheelchairs and carts blocking clear access in case of emergency	In-service will be conducted by the DSD to the C.N.A regarding keeping hallways free of clutter.	DNS	June 28,2002
12	The key to the door of the utility room on the east station was left in the door. The utility room was extremely messy.	In-service will be conducted by the DSD regarding but not limited to: - Keeping the key secured in it's place - Keeping the Utility room clean at all times	DSD	June 28,2002
13	There was dirty linen left on the floor of the bathroom in room 111	An in-service to CNA's will be provided by the Director of Staff Development regarding cleanliness	DSD	June 28,2002

	Recommendation	Comment	Responsible Party	Completion Date
14	The shower room by room 510 was smeared with dried feces	Housekeeping will check all the shower rooms on a daily basis to ensure cleanliness of the area	Housekeeping	June 28,2002
		An in-service to CNA's will be provided by the Director of Staff Development regarding cleanliness	DSD	June 28,2002
15	There was a dirty glove found on the floor of room 517	An in-service to CNA's will be provided by the Director of Staff Development regarding cleanliness	DSD	June 28,2002
16	There was floor damage across the central supply room	Maintenance Director is aware of the damage and will replace the damaged area	Maintenance Director	May-02
17	The rear central patio sliding door screen is badly bent and does not slide properly, causing staff and residents to leave it open allowing flies into the facility	Sliding door screen was replaced by the maintenance director. The sliding door has been fixed and slides properly	Maintence Director	May-02
		Staff are notified and reminded to keep doors and sliding screen door close at all times	DSD	May-02
18	Staffing levels were noted to be below the required 3.2 hours per patient day on several dates reviewed	There is a SEVERE shortage of Nursing staff in the area. Efforts are made to meet the 3.2 hours per patient day - Daily staffing schedules have all shifts covered (un-expected call-offs create shortage) - Overtime shifts are scheduled to fill call-offs On-going recruiting efforts are underway at all times	DNS	Ongoing
19	Nurses notes do not always accurately depict the condition of the residents, and assessment and care plan are not consistent	An in-service will be completed by the Director of Nursing Service to discuss the following but not limited to: - Nurses notes - Nurses Assessment - Care Plan	DNS	June 28,2002
20	The physicians annual history and physical reports are incomplete and do not document an interval history on the resident	Medical Record Designee will conduct an audit of History and Physical and Monthly Visits. Copy of the audit will be forwarded to the Director of Nursing for further follow up.	Medical Record	June 28,2002
		Medical Director to address concerns to Physician if problem exist.	Medical Director	June 28,2002

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
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INSPECTION REPORT SUMMARY #70

Gail Gardner, Administrator
Pioneer House Skilled Nursing Facility
415 P Street
Sacramento, CA 95814

Number of beds: 50

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Pioneer House Skilled Nursing Facility, located in Sacramento, on February 14, 2002. The team identified the following issues which were discussed with the facility Administrator and Director of Nurses during our exit meeting:

Care Issues

1. Treatment sheets lacked signatures for initials.

2. Two of six records reviewed had signed physicians orders that had not been noted by a nurse.

3. Some weekly nurses notes lacked license designations on the signatures. They also lacked appropriate times for the notes.

4. The nurses' notes lacked proper descriptions of wounds/injuries. They also lacked timely notification of the physician and the residents' family.

5. Annual history and physicals lacked interim history and physical findings.

6. Some physician progress notes lacked physical findings indicating contact with the resident.

7. The dietician's assessments of fluid intake needs for the residents were extremely

low and residents received lower than the assessed levels.

8. Several residents in the diningroom were waiting to be fed, but had fallen asleep in their chairs while their food was left uncovered on the table.

9. Staff was not conversing with the residents during the inspection. This was possibly due to the fact that all the CNA's were registry staff filling in for regular staff away at training.

Environmental

10. There was a heavy buildup of lint behind the washers and dryers in the laundry room that could become a fire hazard.

11. Residents complained that staff is too noisy at night.

12. Residents complained about hot food not being hot.

Administrative

13. Some personnel files lacked documentation of reference checks.

14. Most personnel files of licensed staff lacked evidence of CPR training.

15. Residents' personal property inventory sheets were not up to date for the items checked by the auditor.

Staffing

No problems were detected

Fire

Unavailable.

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INSPECTION REPORT SUMMARY #71

Martin Simon, Administrator
Woodruff Convalescent Center
17836 S. Woodruff Avenue
Bellflower, Calif. 90706

Number of beds: 140

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Los Angeles County team conducted a surprise revisit to Woodruff Convalescent Center, located in Bellflower, on February 19, 2002. The team noted that some of the previous areas of concern had been addressed by the facility. Most were just being addressed now, a year after they were noted.

Care Issues

1. Vertical blinds located in many patients rooms were missing many blades, causing a lack of privacy for residents. This was noted repeatedly when the team was touring the outside of the facility and residents were exposed to view while staff were providing care.

2. Nurses notes were improved, but still lack adequate descriptions of wounds, incidents, assessments, and follow up documentation.

3. Some physician's progress notes lack adequate documentation describing an examination by the physician.

4. MDS forms lacked completion and signatures in some cases.

Environmental

6. There are still many sliding door screens which are bent, off track, torn and do not slide appropriately.

7. The facility is still in need of painting and plaster repair in many areas outside.

8. The shed built to store paper records of billing, training, and patient care was found to be unlocked and unattended.

9. Many interior doors are out of alignment.

10. Dirty linen carts were overloaded with wet urine-soaked linen.

11. The base boards in many areas were missing.

12. Handrails in many areas are still in need of sanding and repainting, however the facility appears to be in the process of currently replacing the wooden handrails with metal ones.

13. Water damage was noted on many window sills as noted previously. Only two have been repaired.

14. The floor in the dining room was very sticky before lunch service.

15. The was a buildup of mildew above the sink in the kitchen beginning again.

15. There were both live and dead roaches found in the kitchen.

16. The electrician room in the facility was unlocked and unattended, causing a potential resident hazard.

Administrative

17. Residents personal property inventory sheets were not up to date.

18. Many residents lacked name bands.

Staffing

19. Staffing levels were noted to be below the required 3.2 hours per patient day, some as low as 2.8 hours, especially on week-ends.

Fire

Not applicable.

BMFEA
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INSPECTION REPORT SUMMAR #72

Barbara Mascari, Administrator
Chandler Convalescent Hospital
5335 Laurel Canyon Blvd.
North Hollywood, CA 91607

Number of beds: 201

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On February 20, 2002, the Operation Guardians team conducted a surprise inspection of Chandler Convalescent Hospital, located in North Hollywood. The team identified the following issues, most of which were discussed with the facility Director of Nurses during our exit meeting:

Care Issues

1. The medication cart on Station 2 was noted to be unattended and unlocked in the hallway on two separate occasion by an inspection team member.

2. All the treatment carts, except the one on Station 2, were found to be left in the hallways unlocked and unattended for periods of more than five minutes with the nurse attending to a resident behind a privacy curtain.

3. House stock meds found in the medicine room refrigerators had expiration dates of 9/27/2001. All stock medications should be checked on a regular basis.

4. There was a noticeable lack of signatures on the treatment records for the initials of nurses who provided the treatments.

5. In the medical records it was noted that some medications were ordered without specifying a dosage, just a quantity to be given.

6. Residents were found to be in chairs with trunk restraints, but they lacked either an order for the restraint, signed consent for the restraint, or both.

7. Many residents were noted to need dental care. There does not appear to be appropriate follow up being done by the nursing and social services staff.

8. Most ADL dependent residents lacked proper mouth care. There were dentures found sitting in stagnant, smelly water. There were residents without toothbrushes and/or toothpaste. This was noted on a number of patients in just a small sampling of rooms.

9. Some residents who have dentures listed on their inventory sheets lacked the dentures.

10. Many of the pharmacy consultant records in the residents medical files have nothing but the initials of the pharmacist, with no recommendations noted. These were records which our medical consultants noted were lacking the lab work that is appropriate for many medications such as Dilantin.

11. In general, the nurses' notes lacked detail and documentation of follow up calls to physicians and family following incidents. They also lacked physical exam documentation following falls and other incidents. Measurements were lacking for bruising and other wounds.

12. Residents complained about the noise level in the facility. This was noted by the team. Staff yelling down the hallways and radio's being played at higher than necessary levels.

13. Residents complained about hot food being cold due to lack of staff to pass out the trays. Many trays were noted to be left on overbed tables uncovered, but without the resident being properly set up to eat.

14. It was also noted that some staff failed to speak English in the presence of residents who only understand English.

15. Many of the care plans failed to address issues noted in the nurses notes such as impaction and hydration needs.

Environmental

16. The exit doors have wide gaps and no weatherstripping to prevent cold air and flying insects from entering the facility.

17. There were multiple window and sliding door screens which were bent, torn, off-track and/or missing, which allows flies and other insects into resident areas.

18. There was an electrical cord leading from inside the facility to the parking lot

outside. This creates a danger to both residents and staff, and to any visitors.

19. There was a shed, located near the outside stairway leading to the basement, which contained paints and other chemicals. The shed had a padlock, but was left unlocked and unattended.

20. There was a cable hanging from the roof and trailing across a resident's sliding door to a box near the ground. This could cause a hazard to anyone walking out the door or on the walkway.

21. An exterior door was propped open allowing flying insects into the facility.

22. Flies were noted in the facility, which can lay eggs in open wounds and pressure sores.

23. In the kitchen, there was considerable condensation and frozen condensation noted around the freezer doors, indicating faulty gaskets.

24. There was uncovered and undated food in both the refrigerators and the freezers, including improperly covered pork chops thawing in one refrigerator.

25. There is a soda machine located in a back hallway which is accessed by residents. This allows unsupervised access to the machines by residents who are on restricted diets.

26. The door to the staff lounge was left open and unattended. The room contains a snack vending machine which would allow unsupervised access to the vending machine by residents on special diets who may have choking problems.

27. The shower rooms in general had mildew growing in the shower stalls, dirty linen lying on the floor, broken tiles, damaged drains, drains that were cluttered with debris, and razors left on shower ledges.

28. There was a discarded dressing on the ledge of the shower stall in the shower room by room 15. This is contrary to proper infection control procedures.

29. There were ants noted in the shower room by room 74.

30. Wheelchairs were found being used which had torn and missing armrests, torn seats and torn/cracked backrests.

31. Extension cords were being used in several rooms, connected to television sets and fans. Only power strips are allowed.

32. A purple cleaning fluid and a betadine-type solution were found in the bedside table of one resident. This is a very hazardous situation and all bedside table need to be checked.

33. The bio-hazardous waste storage closet door was locked, but the key was hanging

at the door, which defeats the purpose of locking the door.

34. One pay phone outside room 74 is not operating properly.

35. Most of the hallway handrails were loose when the team began making facility rounds. It was noted that a maintenance person was tightening the rails during the inspection process.

36. The exit door by the staff time clock does not close properly.

Administrative

37. Multiple residents did not have a name band.

Staffing

38. While checking staffing levels, it was noted that staff sign-in sheets were being used inconsistently throughout the facility.

Fire

a. Repair fire assembly doors to close and latch at all fire doors as needed.

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INSPECTION REPORT SUMMARY #73

William Adams, Administrator
Life Care Center of Vista
304 N. Melrose Ave.
Vista, CA 92083

Number of beds: 176

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

Thank you for participating in our inspection of your facility on March 5, 2002. The Operation Guardians team identified the following issues, most of which were discussed with the facility during our exit with you and your Director of Nursing.

Care Issues

1. Many physician's orders were not signed off.

2. Resident 125-3 has capacity to make decisions, yet his son is signing his documents.

    a. There is a question regarding use of Depakote and Celexa together.

    b. There is a question about using Digoxin for a resident that is diagnosed with sinus tachycardia.

    c. The physician was not contacted when a resident had an elevated Creatine and there was no follow up.

3. A resident had an elevated WBC count (16.7) the physician was never contacted

4. Physician progress notes were missing from some charts for several months.

5. Physician orders were not followed regarding resident 125-10 patient with

pressure sores**.**

Environmental

6. There was a strong fecal and urine odor in some bathrooms.

7. Debris was noted on the kitchen floor of the facility

Administrative

8. There were Dignity issues for a patient with their name written on their clothing.

Staffing

No issues were detected

Fire

a. You shall immediately remove the extension cords that are being used to supply permanent electrical power.

b. You shall immediately replace the missing cover plates as indicated during the inspection.

c. You shall immediately remove all multi-plug adapters in use and replace them with circuit breaker protected plug strips.

d. You shall immediately secure all compressed gas cylinder.

e. You shall immediately replace the extinguishers with spares that have current certification.

f. You shall immediately discontinue the practice of wedging or propping open rated doors.

i. Within 30 days of the date of this notice you shall replace or repair all missing and damaged door closers.

ii. Within 90 days you shall repair the kitchen door to enable the self closing function.

g. Within 90 days of the date of this notice you shall have the sprinkler head raised to the correct height and you shall replace the missing trim cover.

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INSPECTION REPORT SUMMARY #74

Robert Henderson, Administrator
Royalwood Care Center
22520 Maple Avenue
Torrance, California 90505

Number of beds: 110

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On March 20, 2002, the Operation Guardian team conducted an unannounced inspection of your facility. The following issues were identified, most of which were discussed with you and your Quality Assurance nurse, and one other staff member during our exit meeting.

Care Issues

1. Physicians' orders were not being signed off, some for as long as two months. Some progress notes were illegible and lacked detail.

2. Resident 126-5 had several pressure sores on the left side of his body which causes concern that the resident is not being repositioned appropriately. His left knee had a previously undiscovered pressure sore, as did his left lateral foot. There was a MD order for a special mattress, which the resident did not have. The care plan indicated heel protectors for the residents already broken down heels, but this was not carried out. The resident was seen expectorating a large amount of mucus. There was no suction apparatus kept near his bed.

3. Resident 126-5 was admitted with dehydration in June of 2001. He was treated for dehydration on March 6, 2002 by administration of IV fluids. On March 20, 2002, the resident's mouth was dry and cracked, his water pitcher was not within his reach and there was no cup to administer his fluids.

4. Resident 126-3 had a sacral ulcer. Her wound had only a 4x4 over it, and it was draining an exudate onto the incontinent pad. Her foley catheter was bunched up

in the side rails and no one noticed. The CNA's repositioned the resident and put tension on her foley tubing and did not notice until this was brought to their attention. This resident's foley catheter tubing was full of sediment.

5. Resident 126-4 was treated with intravenous fluids, but no explanation was provided in the resident's record.

6. There is a concern that the facility has problems with resident hydration. Two residents randomly sampled had to be rehydrated with IV fluids. Three others were noted to be complaining either of thirst or lacking proper hydration methods at the time of the inspection.

7. A resident was noted thirsty, and attempting to drink water from a cup that was only partially filled. Her water pitcher was not in reach and she complained of thirst and hunger.

8. A resident was noted thirsty, and attempting to drink water from a cup that was only partially filled. Her water pitcher was not in reach and she complained of thirst and hunger.

Environmental

9. Bread was open, unlabeled and undated in the kitchen.

Administrative

10. The investigative auditor found that two residents, who expired approx. 5 - 6 years ago, were still having checks reissued and returned, undiscovered by your accounting department.

11. Inventory sheets for patient personal effects were not being updated.

12. Employee personnel files lacked criminal background checks.

Staffing

No problems were detected

Fire

a. Provide "off-site" supervision for fire and sprinkler alarm system.

Special Agent Supervisor, Larry Menard
1425 River Park Drive
Suite 300, Sacramento, CA 95815

April 11, 2002

Dear Mr. Menard,

I have received your letter dated April 2, 2002 concerning the visit to Royalwood Care Center on March 20, 2002. We first wanted to thank you for pointing out various improvements and changes that can be made at Royalwood. We have thoroughly reviewed your findings and have made the following corrections.

#1

a. The checks in question were sent to the Department of Health Recovery section Immediately.
b. A complete audit by the Business Office Manager and the Account Receivable rep was done to ensure no other checks were outstanding.
c. Business Office Manager will be responsible for ensuring that all checks are returned or reissued in a timely manner.
d. Account Receivable representative and Admin. will monitor on a monthly basis to ensure future compliance.

#2

a. In-service was done to nursing staff regarding the importance of keeping all inventorysheets updated.
b. Facility reviewed all in-house patients inventory sheets to ensure they are being updated.
c. Medical Records will be responsible for auditing patients inventory lists on a bi-Weekly basis.
d. Administrator will review audits to ensure patients items are accurately reflected on inventory sheets.

#3

a. C.N.A.'s were in-serviced regarding the importance of ensuring that all water pitchers are within reach.
b. C.N.A.'s and licensed nurses were in-serviced to check water pitchers whenever they are with a patient to ensure all patients have filled water pitchers.
c. As part of the facility's CQI, the DSD will randomly check water pitchers during rounds. Results will be presented to the QA committee in the next two quarters.
d. Administrator and D.O.N. will monitor during daily rounds to ensure future

compliance.

#4

a. Bread was immediately discarded
b. Dietary Supervisor in-serviced all kitchen staff to ensure all bread is properly labeled and dated.
c. All bread will be labeled from the time it is opened to ensure fresh bread at all times
d. Admin and Asst. Admin will randomly check during daily rounds to ensure future compliance.

#5

a. Crash cart was immediately locked
b. Licensed nurses were in-serviced to stress the importance of keeping the crash cart locked.
c. Crash carts are know being kept in the utility rooms which have self-locking doors
d. Admin, Asst. Admin, and D.O.N. will monitor during daily rounds to ensure future compliance.

#6

a. Employee personnel files in question, were immediately updated with background verified.
b. All employee files were updated to reflect completed background checks
c. All new employees will have background checks verified previous to being hired
d. Director of staff development will audit employee files on a monthly basis to ensure future compliance.

#7

a. Physician orders in question were immediately signed off
b. Medical records designee will audit for unsigned orders, so physicians can sign off as soon as possible.
c. Medical records will audit all physician orders and will be made aware of findings
d. Medical records and Admin. will monitor physician orders to ensure future compliance.

#8

a. Patient was immediately repositioned and the special mattress and heel protectors were applied.
b. A complete audit of all patients was done to ensure all patients with orders have correct mattresses and heel protectors as ordered.

c. As part of our Continous Quality Improvement, the DSD and charge nurses will randomly check for repositioning.
d. Admin, D.O.N., and DSD will monitor for repositioning every two hours and use of special mattresses and heel protectors as ordered.

#9

a. Water pitchers was put within reach and another cup was placed at bedside
b. All patient rooms were checked to ensure every patient had a water pitcher and cup was within reach.
c. Grooming nurse was given the responsibility of randomly checking that patients have full water pitchers and they are within reach.
d. Admin, D.O.N., and DSD will randomly check during daily rounds to ensure future compliance.

#10

a. The dressing was immediately changed and the catheter was untangled from the side-rails.
b. C.N.A's and Licensed nurses were in-serviced regarding proper placement of a foley catheter, and the importance of monitoring it.
c. Quality Assurance nurse in-serviced C.N.A.'s on how to monitor foley catheters and the importance of monitoring its placement while adjusting the side-rails.
d. Admin, D.O.N., and DSD to monitor compliance through daily rounds.

#11

a. A late entry was added to the patients chart that reflects justification for hydration
b. Medical records will audit all patients with IV hydration orders to reflect proper justification.
c. QA nurse will randomly audit patient charts to ensure justification is documented for all patients with IV hydration orders.
d. D.O.N. will monitor for continued compliance

#12

a. Facility has a hydration program in place
b. In-service has been given to nursing staff regarding signs and symptoms of dehydration.
c. As part of the facility's CQI program, D.O.N. and DSD will randomly audit IV hydration documentation. DSD will randomly check that hydration needs are met
d. Administrator, D.O.N., and DSD will randomly monitor hydration needs through daily rounds to ensure future compliance.

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Information: (916) 263-3896
Facsimile: (916) 263-0855
Personal (916) 263-0809

INSPECTION REPORT SUMMARY #75

Carole Lillis, RN, Administrator
Santa Monica Health Care Center
1320 20th Street
Santa Monica, California 90404

Number of beds: 59

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

Thank you for participating in our unannounced inspection of your facility on March 21, 2002. The Operation Guardians team identified the following issues, most of which were discussed with the facility during our exit with you and your Director of Nursing. We are attaching a confidential names list for your use.

Care Issues

1. Resident 127-1 - had a previously undiscovered venous stasis ulcer to her right posterior lower leg. The wound was being treated without a physician's order. The physicians order for treatment of the sacral pressure sore was not being followed. The sacral ulcer was being treated incorrectly. There was no dressing on the sacral wound exposing it to feces and urine. There was no care plan or wound sheets for the venous stasis ulcer on the right leg.

Environmental

No problems were detected.

Administrative

2. Resident clothes are not being properly marked to prevent loss or assignment to the wrong resident.

3. Resident inventories are not being updated.

4. Two staff members' personnel records lack the results of PPD.

Staffing

Below minimum daily requirements.

Fire

a. Maintain a 30 inch clearance from all electrical panels.

b. Obtain a fire department permit for the facility.

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INSPECTION REPORT SUMMARY #76

David Hilburn, Administrator
Sherwood Healthcare Center
4700 Elvas Avenue
Sacramento, California 95819

Number of beds: 62

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On April 3, 2002, the Operation Guardians team conducted a surprise inspection of Sherwood Healthcare Center. The team noted the following issues that we discussed during our exit meeting:

Care Issues

1. The medical records review showed that Dr. S. is not visiting his patients in a timely manner, is slow to return calls and FAX's from the facility, and is not dating his signature on the doctors' orders.

2. Some doctors' orders are not being properly noted in a timely manner by the nursing staff.

3. Resident H. needs an updated annual history and physical by Dr. M. Dr. M. is also failing to make timely visits to his patients.

4. Dr. J. signed a blank Advanced Directives form for resident P. when he should sign it after it has been filled out and reviewed by the doctor.

5. Many medications lacked initials to show they had given them as ordered.

Environmental

6. There was a moderate odor of stale urine when the team entered the facility that remained for most of the early morning hours.

7. The storage closet next to the business office was unlocked and unattended. It contained both cleaning chemicals and heavy housekeeping equipment.

8. The hallway closet containing medical records was found unlocked.

9. There was a dirty glove on a shelf and a netted bath scrubber hanging from the shower head in the shower room across from room 14.

10. There appeared to be dried feces on a rug in shower room #2.

11. There were laundry chemicals in the soiled linen room.

12. The key to the bio-hazardous materials/utility room was found in the lock, which defeats the purpose of keeping the door locked.

13. The staff lounge door was propped open by a heavy candy dispenser. Inside were a microwave oven, the staff refrigerator, and a soda vending machine. The door open allows residents unsupervised access to the items that could be hazardous to those who are confused and/or on specialized diets.

14. There were broken tiles in the kitchen near the entrance door.

15. There was a moderate amount of condensation outside the locked freezer door, indicating a worn gasket that could lead to lowered temperatures inside the freezer.

16. There was food in the refrigerator that they did not date.

17. There was a leaking faucet in the dishwashing sink.

18. There was a disposable razor on the ground outside the facility.

19. Near the exit door at the back of the facility, there were excessive items stored outside the sliding doors of several residents rooms, blocking their doors. This could cause a hazard in case of an emergency.

20. The gate behind the facility had been left open.

21. There were two bent screens on residents' windows.

22. The sliding door tracks need cleaning to allow proper sliding of the doors.

Administrative

23. Multiple residents were missing name bands.

24. The personnel file of RN B.-P. E. showed that the license expired on 12/31/01.

Staffing

Below minimum daily requirements.

Fire

Unavailable

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INSPECTION REPORT SUMMARY #77

Michael Mideiros, Administrator
St. Claire's Nursing Center
6248 66th Avenue
Sacramento, CA 95823

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On April 4, 2002, the Operation Guardians team conducted a surprise revisit of St. Claire's Nursing Center, located in Sacramento, on note that nearly all previously identified issues had been addressed and corrected. The following are the issues noted by the team during this visit:

Care Issues

No problems were detected

Environmental

1. There were two window screens which were bent or off-track.

2. The fence separating the facility property from that of the neighbors is rotting, has rusty nails sticking out, and is falling down in many places. Even though this fence is actually on the neighbors property it is a hazard to the residents of the facility and needs to be addressed.

3. One shower room and the tub room had mildew beginning to build up in the corners of the shower stalls. There also was some wall and tile damage in the tub room.

Administrative

4. Some residents did not have name bands.

Staffing

Below minimum daily requirements.

Fire

Not applicable

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INSPECTION REPORT SUMMARY #78

Stephen Fife, Administrator
Asbury Park Nursing & Rehabilitation Center
2257 Fair Oaks Blvd.
Sacramento, CA 95825

Number of beds: 139

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On April 4, 2002, the Operation Guardians team conducted a surprise revisit of Asbury Park Nursing & Rehab Center, located in Sacramento. The team noted that many previously identified issues had been addressed and corrected. The following are the issues noted by the team during this visit:

Care Issues

1. Most of the medication administration records reviewed had signatures missing for the initials of the nurses who had given medications.

2. In the medical records it was found that five of six Advanced Directive forms were signed, but had not been completely filled out.

3. There was a moderate odor of stale urine throughout the facility.

Environmental

4. There was some eave damage noted on the east side of the building.

5. There were some chemical substances left outside which could be hazardous to confused residents.

6. There were some damaged, and/or off track window screens. Most had been repaired from the previous inspection. The window screen in the copy room is missing and the window had been left open.

7. Gates around the facility, and exterior doors, were propped open with bricks or concrete pieces. When brought to the attention of the DON these were removed.
8. There was a leaking faucet in the utility room.

9. In the shower rooms there were used gloves on the floor, mildew beginning in the shower stalls, a razor left in one shower room, and a resident's glasses left in another shower room.

10. The housekeeping closet doors were all found to be unlocked and unattended, and all contained cleaning chemicals. This was also true of some storage closets which also contained chemicals.

11. There were some wastebaskets in residents rooms that were overflowing, allowing used gloves and other trash to spill onto the floor.

Administrative

12. Patients' personal property inventory sheets were not being kept up to date.

13. The team requested a copy of the last fire inspection report, conducted two weeks ago, and has still not received it.

Staffing

Below minimum daily requirements.

Fire

Not applicable

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INSPECTION REPORT SUMMARY #79

Britt Barrett
Sharp Chula Vista D/P SNF-Birch Patrick
751 Medical Center Court
Chula Vista, CA 92010

Number of beds: 100

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On April 9, 2002, the Operation Guardians team conducted a reinspection of Birch Patrick at 751 Medical Center Court, in Chula Vista, California. The team identified the following issues:

Care Issues

1. A review of residents clinical records revealed that respiratory forms were not being filled out correctly. The forms used by the facility states, if oxygen saturation falls below 92% titrate the oxygen.

2. A resident with an implanted cardiac defibrillator was being cared for by the nursing staff without proper care planning for the device. The facility lacked any protocol for the device and the nurses had not been trained or inserviced on the care of a patient with a cardiac defibrillator.

3. A review of several records revealed the Preferred Intensity of Treatment forms were not being signed by residents if they had capacity, and if not, by a family representative.

Environmental

No problems were detected

Administrative

No problems were detected

Staffing

No problems were detected

Fire

Not applicable

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INSPECTION REPORT SUMMARY #80

Gary D. Devoir
Administrator
Care with Dignity Convalescent Hospital
8060 Frost Street
San Diego, CA 92123

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

Thank you for participating in our unannounced reinspection of your facility on April 10, 2002. The Operation Guardians team identified the following issues, most of which we discussed with you during our exit of your facility.

Care Issues

1. Progress notes and nursing notes were maintained on the same sheet of paper and distinguishing one from another was difficult.

2. The history and physical from all charts reviewed were completed on May10, 2001. There was a notation to the physician to please do a physical since it was overdue.

3. A resident was admitted to the facility on February 16, 2002 and had no pressure sores. By March 21, 2002, the resident had acquired a stage II pressure sore to the coccyx. By April 2, 2002, this sore had progressed to a stage III. Nursing notes lacked detail and any significant discussion regarding the resident's progress and declines in status.

Environmental

No problems were detected

Administrative

4. Overall, personnel files were poorly kept. The DSD was unable to identify proper certification for at least two CNAs. One RN had an expired license in her file. The DON lacked an active CPR card.

Staffing

No problems were detected

Fire

Not applicable

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INSPECTION REPORT SUMMARY #81

Floyd Hardcastle, Administrator
Carmel Convalescent Hospital
Highway 1 and Valley Way
Carmel, California 93921

Number of beds: 65

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise revisit of Carmel Convalescent Hospital, located in Carmel, on April 17, 2002. This followed our previous visit on October 1, 2001. The team identified the following issues:

Care Issues

1. Several of the wheelchairs were noted to have torn and cracked seats, backs, and armrests which can be harmful to residents fragile skin.

2. The nurses' notes were still lacking detailed descriptions of injuries including size and color.

3. Assessments are frequently inaccurate, such as fall assessments stating that the resident has no history of falls or fractures when the history and physical sent from the acute hospital states otherwise.

4. The medication administration records are being filled in prior to the appropriate time for incidents of behavior, eating problems, or other issues. For example, being designated as zero at 9:00 a.m. when the shift ends at 3:00 p.m. is not appropriate.

5. Residents were not being seen on a timely basis by the attending physician.

6. Weekly weights noted in the care plans were not documented as done.

7. There was food left at the bedside in room 110, including a container of chicken noodle soup that was cold. With the rodent and insect problems in this facility, the food needs proper storage.

8. Needles and syringes are being stored in an area that was found to be open and unattended.

Environmental

9. There is wall damage above the sink at the nurses' station on the first floor.

10. There were multiple windows and doors in the facility which lacked screens. This allows flies into the facility. There were both dead and live flies found in the storage room.

11. The exterior doors all lack weatherstripping which allows cold air and flies into the facility and warm air out.

12. There were still several windows that had broken and badly cracked glass.

13. The concrete stairway leading to the lower level outside is uneven and a hazard.

14. The walkways around the outside of the facility are all uneven, do not allow for wheelchair and walker access, and are potential hazards to anyone walking around the grounds.

15. There is still a partially covered hole on the side of the facility which needs to be completely covered.

16. There is still a TV cable hanging down blocking clear and safe passage down one outside corridor.

17. There were large deposits of rodent droppings in multiple areas of the facility, particularly in the storage room, the basement, and the staff lounge. There were also multiple other dead and live insects in these and other areas.

18. There was an open door in the diningroom that led to a very hazardous area of pipes, rodent droppings, supplies etc. Although some of the supplies have been cleaned up, it remains dirty, unlocked and hazardous to residents.

19. There was still floor damage in the dining room.

20. The rooms and hallways had very hot radiators which had no protection for the residents to prevent burns. There were resident rooms with the beds and bedspreads against the hot radiators.

21. There are still several leaks noted from the rusted pipes in the basement and storage room.

22. There was a very large hole in the ceiling of the rehab room.

23. The drain hole in the shower room by room 110 is still uncovered, and there are also broken tiles in this shower room.

24. The janitors supply closets still have no locks, and contain chemical cleaners.

25. The hallway handrails are still badly in need of sanding and refinishing to prevent injury to the fragile skin of the residents.

26. The handrail by rooms 216 and 303 are still very loose.

27. There is considerable wall and ceiling damage in the first and second floor utility rooms.

28. Repairs are being made in room 101. However, all repair materials and ladders were left unattended in this open room during the entire morning of our visit.

29. There were multiple leaking faucets throughout the facility. The bathtub in room 208 has a faucet that is dripping steaming water from a highly corroded faucet.

30. In the kitchen pantry there were two loaves of bread left improperly stored.

31. There was considerable wall damage in the kitchen.

32. The door to the outside pantry was open to all animals and cats in the area and contained several different perishable items.

Administrative

33. No problems were detected

Staffing

No problems were detected

Fire

Not applicable.

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INSPECTION REPORT SUMMARY #82

John Paul Jones, Administrator
Pacific Grove Convalescent Hospital
200 Lighthouse Avenue
Pacific Grove, CA 93950

Number of beds: 51

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On April 18, 2002, the Operation Guardians team conducted a surprise revisit to Pacific Grove Convalescent Hospital, located in Pacific Grove. We were pleased to note that you and your staff had addressed all concerns we discussed during our original inspection of January 11, 2001. The following are issues that were noted during this last visit:

Care Issues

1. Physicians' order sheets are being signed by the M.D., but not dated.

2. Licensed staff is not including their signature, license designation and the time when they note the doctor's orders.

3. The nurses' notes frequently lack full descriptions of bruises including measurements and coloring.

Environmental

4. One patio screen was badly bent.

5. There was a small bag of trash which had been knotted and left in the shower room across from room #7.

6. Drawers in some of the residents rooms do not close properly.

7. There was a bottle of Betadine solution left in the room of the resident in room 6 that could be hazardous to confused residents.

8. There was a potential hazard noted on the patio where the carpeting meets the central drain.

Administrative

No problems were detected

Staffing

No problems were detected

Fire

Not applicable

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INSPECTION REPORT SUMMARY #83

Vito Genna,Administrator
Fredericka Manor Care Center
111 Third Avenue
Chula Vista, California 91910

Number of beds: 174

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

Thank you for participating in our unannounced reinspection of your facility on April 23, 2002. The team was pleased to see that you and your staff addressed most of the items previously identified during our first inspection. During this inspection the team identified the following issues, most of which were discussed with the facility during our exit with you and your Director of Nursing.

Care Issues

1. Resident 8-1 had a PPD. with a 14mm induration as documented in her medical record. The facility policy and procedure called for additional follow up besides a chest xray. The physician did not do an assessment on the resident. He stated in the clinical record that no further follow up was necessary.

2. Also, on Resident 8-1, nurses documented use of the Pulse Oximeter. However, there was no physician's order for its use, and no parameters for its use.

3. They treated resident 8-2 for diarrhea and a stool culture was done without proper assessment of the resident's symptoms.

Environmental

No problems were detected

Administrative

4. The DON's personnel file lacked a current CPR card.

Staffing

No problems were detected

Fire

Not applicable

FREDERICKA
MANOR
CARE CENTER

August 14, 2002

Special Agent Supervisor Larry Menard
1425 River Park Drive, Suite 300
Sacramento, CA. 95815

Dear Mr. Menard,

The follow-up re-inspection report was received at Fredericka Manor Care Center on August 02, 2002. Before commenting on actual findings let me assure you that Fredericka Manor Care Center will continue to provide services to our residents with our best efforts and with the closest scrutiny by the residents themselves. In addition to that we will always have the ever-continuing oversight by the State Department of Health Services, Federal evaluators, the Ombudsman and family members. Much is expected, as well as received, from our California nursing facilities. According to the office of Statewide Health Planning and Development data, as many as 40% of residents admitted to skilled facilities throughout the State are discharged home or to prior living arrangements.

I am proud of the care we provide and for the care that most facilities provide. The issues you brought to our attention will be attended to, but we all miss the point when we look for near perfection in a service with a human face on it.

Now to the issues at hand:

1. Since the physician did document that no further follow-up was necessary, we are to assume that that decision was based on his skill assessment of the resident's condition. We will address documentation issues with physicians as the need arises.
2. The Pulse Oximeter is utilized as an assessment tool and is one of the vital signs, just as blood pressure, pulse and respiration. Nursing judgement may indicate it is needed to give the physician a better picture of the resident's condition. The facility does have a policy approved by the Q.A. Committee.

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3. An assessment was done to prompt a stool culture. We will inservice licensed staff to better document their reasoning in making decisions.
4. The D.O.N.'s CPR card was copied and put in her file. The Personnel Director will have a tickler file to ensure.

I am pleased that personnel from your office can appreciate coming into a nursing facility where residents and staff make a difficult situation work to create a lively, healing environment.

Thank you for your attention.

Sincerely,

Vito J. Genna, M.B.A.,
Executive Director

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State of California Department of Justice

Office of Attorney General
Bill Lockyer

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INSPECTION REPORT SUMMARY #84

Charles Sinclair, Administrator
Evergreen Health And Rehab Ctr
3520 Fourth Avenue
San Diego, CA 92103

Number of beds: 194

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

Thank you for participating in our unannounced reinspection of your facility on April 24, 2002. It appeared that almost all of our previous findings were addressed by your staff. The Operation Guardians team identified the following issues, most of which were discussed with you during our exit of your facility.

Care Issues

1. Resident one's medical record lacked a signed Advanced Directive, or Preferred Intensity of Treatment, the H&P from the acute indicated that the resident was a No Code.

2. Resident two was not appropriately assessed for placement at an appropriate level of care.

Environmental

No problems were detected

Administrative

3. Several of the facility licenses and elevator permit were expired. This was brought to the attention of the Administrator who stated he would provide copies of the up to date licenses and permits to the Operation Guardians team. To date,

none has been received.

4. The facility failed to document the amount of induration of the PPDs placed on employees physicals.

Staffing

No problems were detected

Fire

Not applicable

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INSPECTION REPORT SUMMARY#85

Jewell Williams, Administrator
Raintree Convalescent Hospital
5265 E. Huntington Ave.
Fresno, California 93727

Number of beds: 49

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On April 29, 2002, the Operation Guardians team conducted a surprise revisit to Raintree Convalescent Hospital, located in Fresno,. The team was very pleased to note that most of the previously identified issues had been addressed by the staff and had been corrected. During this visit the following issues were noted:

Care Issues

No problems were detected

Environmental

1. There was still an odor of urine and housecleaning solutions throughout the facility.

2. There was considerable equipment and "junk" being stored in an uncovered area outside the facility. The area was surrounded by a low chain-link fence, which could easily be climbed by confused residents.

3. The separate storage building at the back of the facility has a window which had been left open without benefit of a screen. The storage building contained cleaning chemicals.

4. The exit door by room 9 does not close properly.

5. There was a dirty washcloth left in the shower room.

6. The sharps container on the medication cart was full to overflowing, but was changed shortly after it was pointed out to the nurse.

Administrative

No problems were detected

Staffing

No problems were detected

Fire

Not applicable

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INSPECTION REPORT SUMMARY #86

Bart Vander Wal, Administrator
Pacific Gardens Nursing and Rehabilitation
577 South Peach Street
Fresno, CA 93727

Number of beds: 180

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise revisit to Pacific Gardens Nursing and Rehabilitation, located in Fresno, on April 30, 2002. It was noted that most of the issues previously discussed had been addressed by the administration. The following issues were noted during this visit and discussed with the facility administrator by telephone:

Care Issues

1. No problems were detected

Environmental

2. There were three screens on patio doors that were off track. Staff had it repaired before the exit.

3. There were soiled linen, towels and wash cloths, left on the floor of several shower rooms.

4. There was one faucet in the kitchen that was leaking badly.

5. One storage closet outside contained chemicals and had been left closed but unlocked.

Administrative

No problems were detected

Staffing

Below minimum daily requirements.

Fire

Not applicable

PACIFIC GARDENS
NURSING &
REHABILITATION
CENTER

May 23, 2002

Bureau of Medi-Cal Fraud and Elder Abuse
Attention: Larry Menard, Special Agent Supervisor
2025 Gateway Place, Suite 300
San Jose, CA 95110

RE: Operation Guardian Revisit (April 30, 2002)

Dear Special Agent Larry Menard,

The following plan of correction is implemented in response to the findings of your visit:

Finding 1: There were three screens on patio doors that were off track. Staff had it repaired before the exit.

Correction 1: The facility encourages all staff to report maintenance concerns like screen doors off track via the maintenance log books located at each nurse station. A member of the maintenance staff checks and signs the logs a minimum of three times per day. Additionally, the maintenance department will perform complete periodic screen checks to ensure that all screens remain on track and in good order.

Finding 2: There were soiled linen, towels and wash cloths, left of the floor of several shower rooms.

Corrections 2: The Facility performed a shift conference reminding all C.N.A.'s to remove all linen from shower rooms immediately upon exiting the shower room. Housekeeping staff performs scheduled shower room checks. Actual times of these housekeeping checks are logged on a sheet posted to the back of the shower room door.

Finding 3: There was one faucet in the kitchen that was leaking badly.

Correction 3: The maintenance department replaced the leaky fixture.

Finding 4: One storage closet outside contained chemicals and had been left closed but unlocked.

Correction 4: The maintenance department replaced the doorknob. The new doorknob always requires a key to be opened. The new knob does not have an unlocked position.

Please call if you have any questions.

Sincerely,

Bart VanderWal
Executive Director

Pacific Gardens Nursing and Rehabilitation Center
577 South Peach Avenue • Fresno • California 93727
559. 251. 8463 • FAX 559. 251. 4465

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INSPECTION REPORT SUMMARY #87

Joseph Gentilecare, Administrator
Medical Hill Rehabilitation Center
475 29th Street
Oakland, California 94609

Number of beds: 124

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise revisit to Medical Hill Rehabilitation Center on May 14, 2002. The team was pleased to note that the facility administration had addressed most of the previously identified issues. The team identified the following issues.

Care Issues

1. Dr. O. has not signed the physicians order sheets for his residents this year. He is only writing progress notes every other month, rather than monthly, and the progress notes lack physical findings suggesting that he is examining his patient.

2. Resident [redacted] C. may be frequently refusing her medication in the morning, but the staff is failing to properly document the reason they did not give the medication. It is also not care planned and there is no documentation that they have discussed the problem with the physician or the family.

3. The physician's orders and medication administration sheets do not show the quantity to be given for the daily multivitamin ordered.

4. The residents complained about staff being noisy at night.

5. There were no occupancy designations or "Knock Before Entering" signs on shower room doors, and staff was seen entering the rooms without knocking.

Environmental

6. There were wheelchairs and carts blocking both sides of the hallways that could be a hazard during an emergency exit.

7. A team member found the treatment cart on station two unlocked. It contained medicated ointments and razors.

8. The fire extinguisher on the secured unit is badly in need of recharging.

Administrative

9. The "Leave of Absence" sign out/sign in sheets in the residents medical record are not being used consistently. Many lack a return time and signature.

10. The last DHS survey results were not posted in a publicly visible area. It was found after much searching at the nurses station.

Staffing

Below minimum daily requirements.

Fire

Not applicable

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INSPECTION REPORT SUMMARY #88

Robert Ewing, Administrator
Evergreen Castro Valley Healthcare Center
20259 Lake Chabot Road
Castro Valley, CA 94546

Number of beds: 91

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise revisit of Evergreen Castro Valley Healthcare Center, located in Castro Valley, on May 14, 2002. The team was pleased to note that the previously identified issues had been seriously addressed by the administrative staff. The following areas of concern were noted by the team during the revisit:

Care Issues

1. The annual history and physicals for some residents lack an interval history.

2. The station two medicine room and medication cart were both found unattended and unlocked by a member of the team.

Environmental

3. There were some screens on residents sliding doors that had small holes and tears in them. The handle on the screen on the door in room 32 does not allow the door to close properly.

4. There was an odor of urine in the facility when the team entered.

5. There were some handrails in the hallways that were in need of sanding and refinishing to prevent injury to the fragile skin of the residents.

6. Wheelchairs and carts on both sides cluttered the back hallway.

7. The exterior doors, particularly the front entrance, are in need of weatherstripping.

8. Two wheelchairs had cracked seats and arms, which could tear fragile skin.

9. There was a sign inside the door of closet three that stated there were to be no linens stored on the top shelf. However, there were multiple linens on the shelf within 18 inches of the sprinkler head.

10. There was undated and improperly covered food found in the kitchen refrigerator.

Administrative

No problems were detected

Staffing

No problems were detected

Fire

Not applicable

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INSPECTION REPORT SUMMARY #89

Floyd Hardcastle, Administrator
Monterey Convalescent Hospital
735 Pacific Street
Monterey, California 93940

Number of beds: 52

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Monterey Convalescent Hospital, in Monterey, on May 15, 2002. The team identified the following issues:

Care Issues

1. Many physicians' orders lack complete noting by the nurse, including the nurses' signature and license designation, and the date and time the orders were noted.

2. The medication administration records lack signatures for the nurses' initials. These should be done when they give the first medication.

3. They were not answering call lights in a timely manner. Some lights taking more than ten minutes to be answered, while staff was seen passing rooms without checking to see if the resident was in distress.

4. The nurses' notes lack proper complete descriptions for injuries, and pressure sores including full location, complete measurements, and proper color descriptions. They also lack proper descriptions of drainage, color, consistency, amount, and description of an odor.

5. The medication administration records did not always reflect the reason for giving the PRNs and did not document the result of the administration.

Environmental

6. There were no occupancy designations on the shower room doors and staff was observed entering without knocking.

7. Many hallway handrails need sanding and refinishing.

8. The exterior door by room one does not close properly.

9. The front door needs replacement of the worn weatherstripping.

10. The kitchen pantry floor was in need of cleaning.

11. There was some minor window screen damage allowing flies into the facility when the windows are open.

12. The beauty shop was found unlocked and unattended, and contained hair treating chemicals.

13. The supply room was unlocked and unattended and contained syringes and medications.

14. The door frame on the shower room across from room two was badly rusted. The tile in this shower room was cracked and there were rusted shower fixtures.

15. The tub room had several large cracks in the walls and window frames.

16. The light bulb in the tub room across from room two has no cover.

17. There was heavy housekeeping equipment found in an unlocked closet, and could be a hazard to residents.

18. There was floor damage in room 17, and in the hallway.

19. The janitor's closet was unlocked and contained chemicals.

20. A razor was left in the shower room by room 23.

21. Resident medical records were found in an unsecured storage closet.

22. There was a hole in the wall by the open staff lounge, which should be kept closed always.

23. The exit door at the southeast side of the facility is damaged and does not close properly.

24. There was undated food in the kitchen refrigerator.

25. The kitchen screen door does not close properly, and the screen is torn.

26. There were chemicals found outside the laundry room door, unsecured.

27. There was an unsecured storage shed outside which contained chemicals.

28. There was a second unsecured storage shed that also contained chemicals.

29. A television cable was not properly secured.

30. There was concrete damage noted on the north side of the building.

Administrative

31. Personnel files reviewed lacked documentation of reference checks.

Staffing

Staffing was below the required 3.2 hours per patient day on two of the four days randomly checked.

Fire

a. Provide justification by an architect for removal of non rated fire windows adjacent to rated fire windows, or replace with appropriate rated glass and frames.

b. Remove all storage in janitor closet in furnace room.

c. Repair drywall in supply room.

d. Provide fire alarm maintenance records indicating proper functioning of alarms and equipment.

e. Provide generator test records indicating proper emergency fire alarm system back up.

f. Remove all extension cords from activity room.

g. Remove all stored items from corridor.

h. Remove sliding bolts on any doors having them.

i. Remove keyed dead bolt on center exit door.

j. Exit door, east end, and panic hardware need repair.

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INSPECTION REPORT SUMMARY #90

John Henning, Administrator
Country Oaks Care Center
830 E. Chapel St.
Santa Maria, CA 93454

Number of beds: 59

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise revisit of Country Oaks Care Center, located in Santa Maria, on May 29, 2002. The team was pleased to note that the facility had taken seriously the issues previously noted. In particular, the medical records documentation had improved. The team identified the following issues during this revisit:

Care Issues

1. Dr. A. is not dating his signature when he signs the physicians order sheets.

Environmental

2. There was still a moderate odor of urine in the hallways of the facility.

3. There were undated dry goods and undated food in the kitchen refrigerator and freezer.

4. The drain covers in both shower rooms were not properly secured.

5. There were several off track window screens and some torn screens.

Administrative

6. The fire extinguisher by the front nurses' station needs recharging.

Staffing

Below minimum daily requirements.

Fire

Not applicable.

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INSPECTION REPORT SUMMARY #91

Laurie Shea, Administrator
Santa Barbara Convalescent Hospital
540 W. Pueblo
Santa Barbara, California 93105

Number of beds: 62

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise revisit to Santa Barbara Convalescent Hospital, in Santa Barbara, on May 30, 2002. The team was pleased to note that the facility staff had addressed most of the previously identified issues. During this inspection we noted the following issues, and we hope that they will receive the same attention that you gave to the previous issues:

Care Issues

1. The team observed a male CNA while feeding a resident in the diningroom. When feeding the resident, the CNA was talking on a cell phone in Spanish using profanity. This was inappropriate behavior for a staff person at any time while in the facility.

2. We noted that staff was slow in answering call lights, taking as much as ten minutes to answer lights. We observed other staff passing by rooms with lights on without even looking in to find out if the resident were in serious distress.

3. The physicians' orders were not signed for the months of April and May, Dr. S., for resident 02-16-02. There was also an order for "Hgb. & Hct every six months" which they had written twice and they were carrying both over monthly.

4. Some physicians' orders on the charts reviewed were not properly noted by the nurse with the signature, and the date and time the orders were noted.

Environmental

5. There were no occupancy designations on the shower room doors, and we observed staff entering the shower rooms without knocking.
6. The screen on the sliding door in room 16 did not close properly at the time of the inspection.

7. There was a key left in the utility room door by the nurses' station, despite a sign on the door frame stating the key was not to be left.

Administrative

8. When the team entered the facility, most staff was not wearing name tags. This continued until approximately 8:00 a.m. when the charge nurse advised staff to put on their name tags.

Staffing

Below minimum daily requirements.

Fire

Not applicable

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INSPECTION REPORT SUMMARY #92

Tony Ocampo, Administrator
Milpitas Care Center
120 Corning Avenue
Milpitas, California 95035

Number of beds: 35

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise revisit of Milpitas Care Center, in Milpitas, on June 11, 2002. We noted that many issues previously identified had been addressed by the facility staff. The team identified the following issues and hope that you will pay the same attention to addressing them:

Care Issues

1. We still observed residents being transported to the shower room without proper covering. This is a resident dignity issue that you should address immediately.

2. The medication administration records lack signatures for the nurses' initials. These should be done when they give the first medication.

3. The nurses' notes lack proper, complete descriptions for injuries and pressure sores including full location, complete measurements, and proper color descriptions. They lack proper descriptions of drainage, color, consistency, amount, and description of odor.

4. The minimum data sets are incomplete and not done in a timely manner.

5. The care plans do not reflect the status of the resident.

6. There was a moderate odor of urine throughout the facility when the team arrived.

7. Occupancy signs on the shower rooms were not being used properly, and staff failed to knock before entering.

Environmental

8. There were multiple bent, torn and off-track window screens that allow flies into the facility.

9. There was an empty refrigerator left outside without the doors removed.

10. There was a wasp nest under the eaves on the north side of the building.

11. The hallway handrails are in need of sanding and refinishing.

12. There was undated food in the kitchen refrigerator.

13. The bio-hazard utility room was open and unattended, despite the posted sign to keep the door locked at all times.

14. There were several concrete pieces on the south side of the building that could be a hazard to ambulating residents.

15. Oxygen tanks were not properly secured.

16. There was an extension cord being used in room 6 to connect a television for bed A.

17. The storage room by the diningroom was found unsecured and unattended, and contained chemicals.

18. There was an overfilled dirty laundry container in the hallway from which the odor of urine was emanating.

Administrative

19. The residents' personal property inventory records were not up to date.

20. Personnel files lack documentation of reference checks.

21. Staff physicals and TB testing was not up to date.

Staffing

Below minimum daily requirements.

Fire

Not applicable

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INSPECTION REPORT SUMMARY #93

Ben Laub, Administrator
Westgate Rehab & Specialty Care Center
1601 Petersen Avenue
San Jose, California 95129

Number of beds: 258

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise revisit of Westgate Rehab & Specialty Care Center, in San Jose, on June 12, 2002. Overall the team was pleased to note that the administrative staff had taken the previously identified issues seriously and we hope you will give the same attention to the newly identified issues. The team identified the following issues:

Care Issues

1. The medication administration records were missing several signatures for the nurses' initials.

2. We noted that Dr. C. is not dating his signature on the physicians order sheets.

3. The physicians' progress notes for [redacted] G. are poor and do not mention her edema or weight gain.

4. The nurses' notes fail to follow up on issues such as edema and weight gain, though the diagnosis warrants such checks.

5. The care plans do not always reflect the current problems of the resident.

6. RN [redacted] A. needs to be more careful in writing her nurses notes.

7. Too many notes are being written and lined out as errors or written in the wrong record.

8. While passing room two, we observed resident [redacted] H. naked while sitting in a chair. A male housekeeper was mopping the floor around her and no effort was being made to cover the resident, or to notify an aide or nurse to dress the resident. The door to the room was open and no privacy curtain was drawn. A team member reported the situation to the nursing staff.

Environmental

9. The latch needs to be repaired on the soiled linen closet door by room 44.

10. There were several soiled linen containers that were not properly closed, causing a faint urine odor to emanate into the hallway.

11. We noted that the treatment cart was in the hallway unlocked and unattended. As the cart contained medications that could be hazardous to confused residents.

12. There were still several bent and torn window screens on the east and south sides of the facility, and a broken window was noted covered with cardboard.

13. There were several sliding door screens that were off track or did not slide properly.

14. An extension cord is still being used in room 49.

15. There was food in the kitchen refrigerator that was not dated and cover.

Administrative

16. The RN license of [redacted] P. expired 4/30/02 and there is no documentation in the personnel file that they have obtained a current license and that the facility had attempted to verify the update.

17. NA [redacted] C. apparently passed her written CNA exam on 4/4/02. There is no documentation that the facility is following up with DHS to be sure she has received her certification.

18. The RN license of [redacted] A. expired on 12/31/01 and there is no documentation in her personnel file that she has a current license and that the facility has attempted to verify the update.

19. The LVN license of [redacted] A. expired on 8/31/01 and there is no documentation in the personnel file that they have obtained a current license and that the facility has attempted to verify the update.

Staffing

20. Staffing levels were below the required 3.2 hours per patient day on the three days audited**.**

Fire

Not applicable

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INSPECTION REPORT SUMMARY #94

Hope Longerettta, Administrator
Country Villa University Park Healthcare
230 East Adams Blvd
Los Angeles, California 90011

Number of beds: 88

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

Thank you in participating in our unannounced revisit of your facility on June 18, 2002. The Operation Guardians team identified the following issues. The following items were discussed with your staff or you during the exit:

Care Issues

1. A resident is taking Dyazide, a potassium sparing diuretic. The resident is also receiving KCL daily. Pharmacy failed to address this.

2. A resident is receiving Haldol without a proper assessment by a mental health specialist, and diagnosis of psychosis.

3. Personal care items such as leg bags, sitz basins, and bedpans were found in bathrooms unlabeled with patient names.

Environmental

4. Bathrooms with dirty floors, and soiled toilet seats were found on Station I.

5. A container of tar was in an area outside in the facility parking lot in an area accessible to ambulatory residents.

6. A pair of dirty latex gloves were found lying on the curb in front of the facility.

Administrative

7. The DSD failed to verify the current certification of at least three CNA's. One CNA was eventually verified during the inspection, but at least two others were not and are still providing patient care.

Staffing

Below minimum daily requirements.

Fire

Not applicable

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INSPECTION REPORT SUMMARY #95

Julie Alsop, Administrator
Salinas Rehab and Care Center
637 East Romie Lane
Salinas, California 93901

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise revisit of Salinas Rehab and Healthcare Center, in Salinas, on June 25, 2002. The team identified the following issues:

Care Issues

1. Dr. J. is still not signing his physicians' orders in a timely manner and is still not dating the orders when he signs them.

2. Many physicians' progress notes lack physical findings showing that there was no examination being done at the time of the visit as required for payment.

3. The nurses' notes lack detail in the documentation of wounds and bruising. There is poor descriptive detail, including color and proper measurements.

4. The medication administration records still lack signatures for many nurses' initials.

5. There are still some annual history and physicals that are not up to date in the residents medical records and most still lack and interval history and complete physical findings.

6. The notes of the social worker show that the resident Leo A. needs dentures, but there is no follow up documentation and this team member was unable to find the dentures. There is a note in the nurses notes that resident A. was verbally abusive

and had stated to a CNA that he had been hit. There is no follow up regarding the residents claim of abuse. He also has a boil documented on his face that they never properly described or measured.

7. They have not addressed the steady weight gain of resident S. in the care plan.

8. The team observed call lights not being answered in a timely manner. For more than five minutes staff was observed passing rooms with call lights on, without anyone asking as to the residents need.

9. At 8:50 a.m. a female resident was observed sitting in a chair, naked, with a CNA in the room. No privacy curtain was being used and the open had been left open.

Environmental

10. There were still several bent, off track and missing screens on windows and patio doors.

11. The garden hose was again not stored properly on the east side of the building and creates a hazard for anyone walking in the area.

12. The maintenance storage in the back of the facility was again found unlocked and unattended, and still contains items that could be hazardous to wandering residents.

13. There was still a moderate odor of urine throughout the facility.

14. They have moved the snack and soda vending machines to the staff lounge. However, despite a sign on the door requiring the door be kept closed at all times, it was propped open by a large trash container on the several occasions that the team members passed by.

15. Many residents sliding door screens do not slide properly, causing them to bend when they are forced open.

16. A washcloth was holding the back exit door to the laundry open.

17. There was repackaged food in the kitchen freezer that they did not date.

18. There was no screen on an open kitchen window.

19. There is a broken flower container on the patio.

20. A used ostomy bag was left in the shower room.

21. The sewer cover on the east side of the building was found on the walkway.

22. There was mildew beginning in shower room A.

23. Several issues noted by DHS during the last annual survey have not been addressed:

    a. the door panel in room 8 is still peeling

    b. the toilet in room 5 is still cracked

    c. they have still not painted the door in room 12

    d. the door panels in rooms 12, 42, and 15 are still cracked

    e. the dresser drawers in rooms 15 and 42 still need painting

    f. the bathrooms in rooms 27 and 42 still need painting

24. Medication again was being stored next to food in the medication refrigerator.

25. There was no indication when the last fire inspection was done on the sprinkler system standpipe. It is required to be inspected every five years. The administrative staff was unable to produce a report within the past five years, regarding the standpipe inspection.

Administrative

26. The personnel file of [redacted] A[redacted]., CNA, has no documentation to show he obtained his certification. All records for 2001 state it is pending and there is nothing documented since 1/4/01 to indicate that the facility has done any follow up.

27. Two of the six personnel files reviewed lacked documentation of references being checked.

28. There was no record of TB testing for [redacted] G[redacted]. or [redacted] H. in their files.

Staffing

Staffing was below acceptable levels on all dates reviewed.

Fire

Not applicable

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INSPECTION REPORT SUMMARY #96

Linda Trevino, Administrator
Katherine Healthcare Center
315 Alameda Street
Salinas, California 93901

Number of beds: 51

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On June 26, 2002, the Operation Guardians team conducted a surprise revisit of Katherine Healthcare Center, located in Salinas. The team identified the following issues:

Care Issues

1. The shower rooms now have occupancy signs, but they are not being used properly. Staff is not answering when someone knocks either. Staff is also not closing the shower room door properly when they occupy the room.

2. The medication administrations' records lack signatures for some nurses' initials.

3. Resident [redacted] M. needs an annual history and physical update (last done on 4/12/01), and his orders signed by the physician on 6/12/02 were not noted properly by the nursing staff.

4. The nurses' notes lack a complete description and measurements of the surgical wound when the resident returned to the facility.

5. The progress notes of Dr. B. are minimal and lack complete physical findings.

6. The nurses' notes still lack proper detailed descriptions and measurements of wounds and injuries. They also lack documentation of follow up for possible later bruising and evidence of injury.

7. The monthly physicians' orders of Dr. H. for resident [redacted] P. have not been signed since 3/27/02, and were not being regular signed and dated before that date. This resident also needs and updated history and physical, with an interim history, as the last one is dated 3/26/01.

Environmental

8. A garden hose was left out across the yard in back, creating a hazard to anyone walking in the area.

9. Handrails in the facility hallways are in need of sanding and refinishing.

10. The screen door in the kitchen is bent and does not close properly, and there were several gnats noted in the kitchen pantry area.

11. There were several flies noted in the upstairs resident areas.

12. The handrail by room 25 is loose.

13. There were still multiple bent, torn and off-track screens on residents windows, some with open windows and missing screens.

14. There was still uneven concrete outside in resident areas that could be hazardous to residents ambulating in the area.

15. There was a heavy build up of lint outside where the dryer vent blows, which could create a fire hazard.

16. The maintenance equipment room was open and unattended.

17. There is a large hole in the ceiling in the bathroom by the laundry.

18. There is a pipe sticking out of the ground outside the patio gate leading to the parking lot that is causing a hazard to anyone walking that area.

19. The north building exit does not close properly.

20. The beauty shop door was unlocked and the area unattended. It contained hair treatment chemicals.

21. The floor tile in the diningroom is coming up.

22. The radiator panel and floor base board in the diningroom is coming out.

23. The door to the staff lounge was propped open with snack and soda machines inside.

24. Three geri-chairs were found to have torn armrests and need to be repaired to prevent injury to residents using them.

25. The upstairs medication room was unlocked and unattended.

26. There was a heavy duty extension cord being used in room 29.

27. The handrails are still very rough and could cause injury to the fragile skin of the residents.

28. Several DHS deficiencies noted in the survey completed 11/08/01 are still a problem:

    a. Items 1-4, page 16 of the survey.

Administrative

29. Personnel file of [redacted]. B. lacks documentation of reference checks, and documentation of the second step of TB testing.

30. Personnel file of [redacted]. G. lacks documentation of her certification as a CNA and her expiration date.

31. Personnel file of [redacted]. A. lacks an up to date certification as a CNA documented in her file, expired 12/31/01.

Staffing

Staffing on Sunday 4/14/02 was well below the minimum required. All other days reviewed by the team were acceptable.

Fire

Not applicable

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INSPECTION REPORT SUMMARY #97

Yvette Bonnet, Administrator
Almaden Health and Rehabilitation Center
2065 Los Gatos-Almaden Road
San Jose, California 95124

Number of beds: 77

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Almaden Health and Rehab Center, in San Jose, on July 9, 2002. The team identified the following issues:

Care Issues

1. The medication administration records and treatment records lacked signatures for the initials of the nurses who administered the medications and treatments.

2. The medication administration records lacked results on the PRN medications given.

3. The nurses' notes lacked complete descriptions of injuries including color and measurements, exact location, and pain assessment.

4. Residents complained of inability to get assistance from staff between the hours of 6:00 and 9:00 p.m.

5. A Hispanic male CNA was observed feeding a resident in the diningroom. The CNA sneezed and wiped his nose with his hand, and then continued feeding the resident. A team member observed this at approximately 12:50 p.m. during the inspection.

6. The care plan for resident 02-22-07 lacked planning for the oxygen and for the surgical wound care.

7. We noted that Dr. [redacted] R. is not making the necessary monthly visits to his patients. His progress notes lacked physical findings showing an examination of the resident was done.

8. Most physicians are not dating their orders when they sign them. The doctor should date all physicians' signatures.

9. The preferred intensity of care indicates that the resident, 02-22-02, is no-code. However, it is not signed by the resident and her orders from Kaiser show she is to be full code.

Environmental

10. The sprinkler head in the linen closet did not have proper clearance space from the sprinkler to the linen.

11. There were snack and soda vending machines in the back diningroom which allowed unsupervised access to high sugar and high sodium snacks to residents who may be on restricted diets.

12. There was a loose handrail by room 20.

13. The light in the shower room needs to be replaced.

14. There was trash and dirty gloves found around the exterior of the facility building.

15. There were two leaks noted in the pipes of the water heater in the shed.

16. There was a leaking pipe in the water softener unit.

17. There was trash littering the outside of the facility.

18. Full and half-full laundry chemical containers were propping the door to the laundry room open.

19. There was wall adhesive left on a shelf in the hallway, unsecured.

20. There was a large puddle of standing water in the kitchen under the dirty dishes rinsing area.

21. The sprinkler head in the linen closet by room #8 did not have the required 18-inch clearance.

22. There was an improperly stored garden hose on the side patio.

23. There was a wasp nest noted under the eaves of the patio.

24. There was an off-track sliding door leading to the patio.

25. There was mildew beginning in two shower rooms.

26. There were soiled gloves left in the shower rooms.

27. There was a razor left in an unlocked box in the shower room.

28. There were small oxygen tanks in the closet that were not properly secured.

29. There was substantial wall damage to the exterior wall of the front conference room.

30. The outside janitors' storage room was found open and unattended.

Administrative

31. Residents' personal property inventory sheets were not up to date and often had not been done at all.

32. Residents' personal property was not properly labeled with the resident's name.

33. The personnel file of the DON, [redacted] E[redacted]. lacked a current license and expiration date.

34. The personnel file of [redacted] A[redacted]., the assistant DON, lacked a current license and expiration date.

35. The personnel file of CNA [redacted] A[redacted]. lacked a current certificate and expiration date.

36. The personnel file of CNA [redacted]G. lacked a current certificate and expiration date.

Staffing

Staffing for the three days reviewed were below the minimum requirement of 3.2 hours per patient day. One day, 6/15/02, was only 2.55 hours.

Fire

No problems were detected

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INSPECTION REPORT SUMMARY #98

Blaine Lyons, Administrator
Terreno Gardens Extended Care
14966 Terreno de Flores
Los Gatos, California 95032

Number of beds: 65

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Terreno Gardens Extended Care Facility, in Los Gatos, on July 10, 2002. The team identified the following issues:

Care Issues

1. Dr. [redacted] W. uses the services of a physicians' assistant (PA), but fails to review and cosign the notes of the PA.

2. Dr. C. signs his physicians' orders, but fails to date them. All doctors' signatures should be dated. Residents complain that he never sees them. His progress notes lack physical findings to show that he was examining his patients as required, and he fails to visit on a regular basis.

3. The medication administration records lack signatures for the nurses' initials. These should be done when the first medication is given.

4. The nurses' notes lack proper complete descriptions for injuries, and pressure sores including full location, complete measurements, and proper color descriptions. Further, they lack proper descriptions of drainage, color, consistency, amount, and description of the odor.

5. The station one med. room was found propped open and unattended.

Environmental

6. The handrail between rooms 33 and 32 is loose.

7. There is a leaking shower head on station two.There was a garden hose across the pathway of the side patio that they did not store properly, creating a potential hazard to ambulating residents.

8. There was a substantial hole in the fence bordering the facility property.

9. There was one bent window screen that needs fixing.

10. There were cables hanging down the side of the facility that could be a potential hazard to ambulating or confused residents.

11. There was a large hole found on the side of the building that a board partially covered. This creates a hazard to ambulating residents and should be filled or covered completely.

12. There was dirty linen left in the station one shower room.

13. The roof overhang on the south side of the building is torn underneath and needs repair.

14. There is uneven and pitted concrete on the patio creating a potential hazard to ambulating residents.

15. The patio tables are old and cracked and present a potential hazard to the skin of the residents.

16. The screen on the back door of the kitchen is missing the bottom panel.

17. There is a hole in the wall under the dish rinsing area of the kitchen.

Administrative

18. The residents' personal property inventory records were not up to date.

19. There is no TB testing documented in the personnel file of LVN [redacted] C.

20. The personnel file of CNA [redacted] C. contains no up to date certification and expiration date. The last one listed expired 6/5/2001.

21. The personnel file of DON [redacted] V. lacks a current license and expiration date. It also lacks any documentation of TB testing and physical examination.

Staffing

Only one of the six days of staffing reviewed by the team showed the minimum required 3.2 hours per patient day. Two of the days were below 3.0 hours.

Fire

No problems were detected

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INSPECTION REPORT SUMMARY #100

Village Square Nursing and Rehab Center
Charles Sinclair, Administrator
1586 W. San Marcos Blvd.
San Marcos, CA 92069

Number of beds: 118

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On July 16, 2002, the Operation Guardians team conducted an inspection of, Village Square Nursing and Rehabilitation Center**,** the team identified the following:

Care Issues

1. We noted that Resident (24-01) had a history of skin tears and bruising. A CNA was observed attempting to reposition this resident using an incontinent pad and dragging the patient across it. The resident had a skin breakdown on her coccyx and buttocks.

2. The facility did not track the acquisition or progression of pressure sores adequately.

3. Wound care sheets were poorly kept and lacked pertinent documentation.

4. There was an overall lack of coordination of care and assessment.

5. Many charts were missing consents for use of psychotropic drugs.

Environmental

No problems were detected.

Administrative

6. Personnel files revealed that TB screening was not being done properly. Staff with positive PPDs were not receiving follow up. One employee with a positive PPD. and receiving INH, had no follow up.

Staffing

7. We calculated and found that staffing was outside the desired parameters for 6/15, 6/16, 6/21, 6/22 and 6/23.

Fire

Unavailable

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INSPECTION REPORT SUMMARY #101

Marvin Levenson, Administrator
Villa Pomerado D/P SNF
15615 Pomerado Road
Poway, California 92064

Number of beds: 129

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On July 17, 2002, the Operation Guardians team conducted an inspection of your facility. The team identified the following issues:

Care Issues

1. A resident was observed twice, at both breakfast and lunch unable to access her food tray due to it being positioned out of her reach. At breakfast, the tray was removed and the resident went unfed. Staff did not assist the resident with her meal. At lunch the tray was, again, out of reach due to equipment being positioned improperly. The chair was too low and the tray table was too high.

2. A resident lacked water at her bedside. When asked a CNA stated the resident was on thick liquids. However, the resident's MD orders and Nutrition assessment stated, thin liquids.

3. Some clinical records were missing signatures, and physicians orders were missing frequency of dosing and route of administration.

Environmental

4. No problems were detected

Administrative

5. A CNA with a history of being verbally abusive to residents was not suspended until DHS discovered an incident and investigated, based on numerous resident complaints.

Staffing

No problems were detected

Fire

Unavailable

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INSPECTION REPORT SUMMARY #102

Terry Balisteros, Administrator
Manor Care of Citrus Heights
7807 Uplands Way
Citrus Heights, California 95610

Number of beds: 148

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Manor Care of Citrus Heights, located in Citrus Heights, on July 23, 2002. The team identified the following issues:

Care Issues

1. Several staff members complained about a lack of staff to answer call lights in a timely manner.

2. Medication administration records lack signatures for the nurses' initials.

3. Physicians' orders are not properly noted with the nurses signatures, and the date and time of the noting of the orders.

4. Multiple residents had eye infections in the month of June 2002, but at least two lacked a care plan for the problem.

5. There have been a high percentage of infections of various types among the residents of the facility and a lack of proper infection control procedures. A new infection control policy manual was approved on 7/16/02, but insufficient time has elapsed for the team to make an assessment of the effectiveness of the new policy.

6. It was noted that some pharmaceutical psychotropic drug summaries had not been completed as required. This was also noted by the facility pharmacy consultant.

7. Despite the pharmacy consultant's note in his report that the use of the pain scale was not being used properly, the issue is still present.

8. There were no occupancy signs noted on the shower room doors and staff was seen taking residents into the rooms without knocking first.

9. The annual history and physicals were not up to date for residents #02-27-09, #02-27-08, #02-27-06, #02-27-05, and #02-27-03.

10. The nurses' notes lacked detailed descriptions of pressure sores with exact measurements, descriptions of color, drainage and drainage amounts. The nurses' notes also lacked detailed descriptions with measurements and proper location of injuries and bruises. They also lacked follow up as to the cause of the injuries.

Environmental

11. There was food previously prepared for the day, left uncovered in the walk-in refrigerator in the kitchen.

12. There was undated food found in the walk-in refrigerator and the other refrigerators in the kitchen.

13. The facility had been broken into the night before the inspection, so there was still broken glass in the lobby and office areas, but none noted in resident areas. One of the front windows was completely gone and was not properly covered to prevent flies from getting into the facility.

14. There were multiple flies inside the facility, including resident and kitchen areas.

15. The door to room 606 still sticks, as noted by DHS in their last survey.

16. There was a broken tile noted at the threshold of the facility entrance.

17. There were a few bent and off track window screens, which will also allow flies into the facility.

18. There was trash strewn about on the residents' patio, especially in the garden areas.

19. There were several wasp nests noted under the eaves of the facility.

20. There were improperly secured oxygen tanks outside at the rear of the facility.

21. There was no lint catcher on the laundry room dryer vent, a potential fire hazard.

22. An extension cord was being used in room 705, contrary to regulations. There was a second extension cord coming from a resident's room and extending across

the hallway, plugged into a hallway electrical outlet. This was considered a hazard to anyone walking down this hallway.

23. There were multiple chipped tiles noted in the upstairs shower room.

24. There were several overstuffed dirty laundry containers found in an upstairs shower room.

25. There was damage noted to the door of the upstairs shower room.

26. There was clean linen found on the floor of the clean linen closet upstairs.

27. There was a dirty dressing found on the floor of a shower stall in the downstairs shower room, along with soiled, wet linen left lying on the floor.

28. There was wall damage noted in the laundry room.

29. The kitchen pantry was crowded with cases of kitchen goods, and did not allow access to most of the food in the pantry.

Administrative

30. Three of the nine personnel files reviewed lacked up to date license/certification dates, and lacked documentation that staff had been in touch with the licensing agency to verify these employees' current license/certificate status.

31. The personnel files lacked documentation that references had been checked.

Staffing

Three days were reviewed at random for proper staffing levels. Only one day was at or above the required 3.2 hours per patient day. This was especially noticeable on weekends and holidays.

Fire

Unavailable

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INSPECTION REPORT SUMMARY #103

Patrick Kinney, Administrator
Sunbridge Fountainview Care Center
2540 Carmichael Way
Carmichael, CA 95608

Number of beds: 178

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Sacramento County team conducted a revisit of Sunbridge Fountainview Care Center, located in Sacramento, on July 23, 2002. The facility still had a number of issues noted by the team. Those issues are listed as follows:

Care Issues

1. The treatment cart was noted to be parked across from room 51 and was left unlocked and unattended.

2. Both the medication and treatment administration records lacked nurses' signatures for their initials.

3. Physicians' orders were not consistently being noted by the nurses.

4. Progress notes by Dr. R. were missing for three of six months reviewed. This would indicate that he is not visiting his patients on a regular monthly basis.

5. Progress notes written by Dr. [redacted] J. were not legible and would affect continuity of care should Dr. J. be unable to visit her patients.

6. Residents complained that the facility was extremely noisy at night with staff yelling and street noise keeping them awake.

7. Residents complained about not seeing their doctors on a monthly basis, particularly Dr. R.

Environmental

8. There was a cracked light fixture in the day room across from room 621.

9. The bathroom across from the administration office was dirty with feces on the toilet seat.

10. The shower room by room 616 was dirty, feces on the floor in several places, and dirty wash-cloths left on the floor.
11. There was a used glove found on the floor in room 606.

12. There was glass on the floor in the hallway outside nurses station six.

13. The vent in room 602 was blowing out particles that were hitting the resident in the face. Vents in the day room were very dirty.

14. Multiple closet doors in residents rooms were off-track.

15. There were trash and a used glove on the floor in the storage room across from room 42.

16. Oxygen tanks were not properly secured by room 51 and by the nurses' station.

17. Extension cords are being used in room 30.

18. The shower room between room 30 and 31 had no drain cover. The faucets were leaking, there was mildew in the corners and there was dirty linen left on the floor.

19. The electric wheelchair for the resident in room 34 needs repairs.

Administrative

No problems were detected

Staffing

No problems were detected

Fire

Not applicable

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INSPECTION REPORT SUMMARY #104

Sheila Waddell, Administrator
McKinley Health Care Center
3700 H Street
Sacramento, California 95816

Number of beds: 86

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of McKinley Health Care Center, located in Sacramento, on July 24, 2002. Due to a clerical error, this letter may not have been sent to you. The team identified the following issues:

Care Issues

1. Nurse [redacted] T. was observed giving Tums to a resident without a physician's order. She did not sign the medication administration record for giving the Tums, although there was an order for Milk of Magnesia. She also left the team members alone in the medication room without asking any identifying questions.

2. Many physicians' orders reviewed by the team were not properly signed by the physician, even when there was a progress note for the month.

3. The medication administration records lack signatures for the nurses' initials. These should be done as soon as the first medication is given.

4. Dr. D. is not seeing his patients within 72 hours of admission as required.

5. Several drug doses were noted to be incorrectly written or were transcribed incorrectly.

6. Many of the physician's progress notes lack physical findings of the required monthly exam of the patient.

7. Care plans were found to be incomplete and do not accurately reflect the needs of the resident.

8. Resident assessments were not done in a timely manner. They were incomplete and did not accurately reflect the abilities of the resident.

9. Both breakfast and lunch were served more than 30 minutes after the posted serving time. When meals were served to the residents in their rooms, the staff did not open drapes or turn on lights. They left the trays on the table without setting the residents up for lunch. Many were left without the warming cover in place. The trays were left and the residents' room door was closed without waking the resident.

10. The resident in room 33B was found on the patio eating pizza he had ordered from an outside restaurant. His tray was left at his bedside with no attempt by the staff to locate him.

11. The progress notes of Dr. [redacted] S. were difficult to read, lacked physical findings, and lacked the year and the date. This could all adversely affect the continuity of care should something happen to the physician.

12. Residents complained of staff being very noisy at night.

13. Residents complained that staff ignored their requests and "just close the door."

Environmental

14. The bathroom doors in most of the residents' rooms do not open and close smoothly.

15. Multiple wheelchairs had cracked arms and backs which could damage residents fragile skin.

16. There were several flies found in the facility.

17. The rear exit door of the facility does not close properly.

18. The screens on nearly all the patio doors were off-track.

19. The kitchen was generally cluttered and the floor was dirty.

20. There was improperly stored food in both the kitchen refrigerator and freezer.

21. There was rotting fruit and a dirty glove on the walkway on the east side of the facility.

22. There were several fans in the hallways to cool the facility, and the cords were sometimes crossing emergency exits and the hallway itself.

23. There were clean linens on the floor of the linen closets and dirty linen on the floor of the shower rooms.

24. There is no light fixture cover in room two.

25. There were no screens on the open windows of the diningroom, allowing flies throughout the facility.

26. There was floor damage and a broken window in the diningroom.

27. The patio had trash strewn around, including a pillow, along with an improperly stored garden hose, and a pressure washer. There was also a chair on the patio with a sign on it stating "psycho seat."

28. There was wall damage in room 34.

29. The hallway handrail was broken across from room 38.

30. There was slime noted under the laundry room cooling unit, and under several of the down spouts.

31. There were laundry chemicals left outside the laundry room.

32. Exterior doors lacked weather-stripping.

33. In the shower rooms there is standing water in the tub that was not draining properly. There also was missing grout in the tiled areas, holes in the walls, chipped and missing tiles in the shower stalls, and mildew in the corners of the shower stalls.

34. There are soda and snack vending machines in a location which allows residents unsupervised access. This can be hazardous to residents who are confused, are on sugar or sodium restrictions, or have choking problems.

35. There were expired flu vaccine and food in the medication refrigerator.

36. The staff lounge door was propped open and could be hazardous to the residents.

Administrative

37. The resident in room 33B signed an admission agreement on the day of the inspection, but it was back dated by facility staff to the date of the actual admission (6/27/02).

38. Ten personnel files were reviewed. Two had expired license/certification in the file, four lacked documentation of reference checks, two lacked documentation of elder abuse training, and three lacked up-to-date physical examinations

documented.

39. Residents' personal property inventory sheets were not up-to-date and residents' personal property was not all properly labeled.

Staffing

No problems were detected

Fire

Unavailable

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INSPECTION REPORT SUMMARY #105

Barbara Khatchadurian, Administrator
Santa Clarita Convalescent Hospital
23801 San Fernando Road
Newhall, CA 91321

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

Thank you for participating in our unannounced inspection of your facility on July 24, 2002. The Operation Guardians team identified the following issues, most of which were discussed with you during our exit of the facility:

Care Issues

1. On June 8, 2002, a resident consumed 90% of a bottle of Peri-wash. On July 24, 2002, we noted a bottle of Peri-wash on a patient's overbed table. This bottle was unlabeled.

2. On July 31, 2002, resident 30-05 told the staff he was going to have a seizure and did. The resident was sent to the emergency department of a local hospital.

3. On January 5, 2002, resident 30-03 was smoking in a designated area and her hair caught on fire, no injuries were sustained.

Environmental

No problems detected

Administrative

4. No problems detected

Staffing

No problems were detected

Fire

Unavailable

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INSPECTION REPORT SUMMARY #106

Cloverleaf Healthcare Center
Mario Bertumen, Administrator
275 N. San Jacinto
Hemet, CA 92343

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On July 30, 2002, the Operation Guardians team conducted an inspection of your facility. The team identified the following issues:

Care Issues

1. The team identified a substantiated sexual assault that occurred in your facility that was reported to the local law enforcement agency and you discharged the perpetrator from service. However, the facility failed to provide adequate sexual assault examination by experienced knowledgeable sexual assault specialist. The facility also failed to preserve the crime scene, and failed to provide sexually transmitted disease testing to the victim(s).

2. Nursing staff failed to assess a resident for the presence of skin lesions that may be shingles. The nursing staff did not know the lesions were present. The Operation Guardians team nurse and physician identified this.

Environmental

3. No problems were detected.

Administrative

4. A resident reported the theft of a purse and money. The facility failed to inform local Law Enforcement, and did not replace the lost funds.

5. The facility failed to properly screen and follow up on tuberculosis screening of staff.

Staffing

No problems were detected

Fire

Unavailable

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INSPECTION REPORT SUMMARY #107

Devonshire Care Center
Lori Giorgis, Administrator
1350 E. Devonshire Ave
Hemet, CA 92343

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On July 31, 2002, the Operation Guardians team conducted an inspection of your facility. The team identified the following issues:

Care Issues

1. Two elderly residents reported being sexually abused by a male CNA who was entrusted with their care in May 2002. One of the resident victims stated she immediately advised a staff person of the incident. Due to inadequate internal handling of the report, the facility failed to contact local law enforcement in a timely manner. The police were not contacted until August 1, 2002. As a result, potential crime scene evidence was not preserved and therefore unavailable for proper collection by forensic examiners. Additionally, the victims were not afforded a professional sexual assault examination and the victims did not receive a sexually transmitted disease screening. As you are intrusted with the care and well being of residents, it would be appropriate to offer psychological testing and support for those residents who do report such incidents.

2. According to patient interviews and documentation from Resident Council Minutes, residents of the facility were not getting regularly scheduled showers. Most complained that the facility had not showered them in two weeks.

3. Residents complained that staff did not answer call lights and when they asked for assistance, staff verbally chastised or ignored residents.

4. A resident complained that she needed help with feeding herself. Typically, according to her report, staff would leave her tray out of reach and retrieve it with the food uneaten. This resident had dentures, but staff was not applying adhesive to them even though the dentist had documented that the resident needed this. The facility failed to assess this resident for a feeding program.

5. Operation Guardians team members and our physician interviewed a resident. We also gave the resident a screening for cognition. Her record documentation characterized her as lacking the ability, mentally, to understand what was going on around her. Her record further documented that she had a bad memory. The DON noted that the information in the record was not consistent with the assessment and stated she would change it.

Environmental

6. The facility did not test their dishwasher for proper ability to sanitize the plates, utensils and other objects used to prepare and serve food to residents. Because they were filling the sanitation logs with incorrect information and the staff lacked the knowledge of proper sanitation, it was unclear how long the dishwasher had not provided proper sanitation. This situation exposed residents to disease. The kitchen supervisor did not immediately employ emergency sanitation of dishware when the dishwasher was out of service. She lacked the knowledge of a three or two sink sanitation system.

Administrative

7. The facility documented a CNA with patient contact as having tuberculosis with a negative chest xray. The facility provided no further follow up on this CNA.

Staffing

No problems were detected

Fire

Unavailable.

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INSPECTION REPORT SUMMARY #108

Victoria Alexander, Administrator
Ojai Valley Community Hospital SNF
1306 Maricopa Hwy
Ojai, California 93023

Number of beds: 66

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On August 6, 2002, the Operation Guardians team conducted a surprise inspection of Ojai Valley Community Hospital SNF, in Ojai. The team identified the following issues:

Care Issues

No problems were detected

Environmental

1. The hallway handrails are in need of sanding and refinishing to prevent skin tears.

2. Used gloves were found on the floor next to the waste baskets.

3. The exterior doors are in need of repair for some wood damage and all need weatherstripping.

4. The janitor's closet by the east nurses station was found unlocked and contained chemicals.

5. Extension cords were found in two residents' rooms, the laundry room and the kitchen pantry.

6. There were no occupancy signs on the shower room doors, though we observed no improprieties, this could become a privacy issue for some residents.

7. There was a wasp nest beginning under the eaves in the corner of the patio.

8. There was an unsecured ladder by the kitchen exit.

9. There were broken tiles in the shower room near the doorway.

10. The utility storage rooms in the rear of the facility lack locks on the doors, and contained cleaning chemicals.

11. There were two sliding door screens that were off track.

12. The Fire Inspector noted several Fire Department violations that she itemized in her inspection report.

Administrative

No problems were detected

Staffing

No problems were detected

Fire

a. Clear storage from back corridors and exits.

b. Replace cap on fire department connection.

c. Replace ceiling tiles in outside wash room (north side of bldg.)

d. Replace fire sprinkler escusion in outside wash room (north side).

e. Provide exit sign on inside kitchen door with panic hardware.

f. Remove extension card from dietary cold storage room.

g. Remove multi outlet extension card from laundry room.

h. Remove extension cord from room 218 on tv.

i. Provide Department of Transportation sign on oxygen storage room.

j. Remove or replace fire extinguisher in Rehab room.

k. Do not block fire door with coffee cart near dining room.

l. Relocate trash cans outside to provide fire department access.

m. Repair hole in laundry room wall.

Ojai Valley
Community Hospital

December 9, 2002

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice
Special Agent Diana Boutin
2025 Gateway Place
Suite 300
San Jose, CA 95110

RE: Response to Operation Guardians Inspection; Plan of Correction

Dear Ms. Boutin:

We are responding to your issues found while the Operation Guardians team conducted a surprise inspection of our facility on August 6, 2002. This was communicated to us in a letter received on December 4, 2002.

1. The hallway handrails are in need of sanding and refinishing to prevent skin tears.

RESPONSE: Hallway handrails are being reconfigured with a router and refinished with the expected completion date of all handrails by March 1, 2003.

2. Used gloves were found on the floor next to the waste baskets.

RESPONSE: Staff, wearing gloves, have received inservice regarding need to always dispose of gloves into the appropriate receptacle.

3. The exterior doors are in need of repair for some wood damage and all need weatherstripping.

RESPONSE: Exterior doors have been repaired and weatherstripping has been installed.

4. The janitor's closet by the east nurses station was found unlocked and contained chemicals.

RESPONSE: Housekeepers have received inservice regarding need to lock all janitors' closets at all times. Nursing will continue to assist with monitoring doors.

5. Extension cords were found in two residents' rooms, the laundry room and the kitchen pantry.

1306 Maricopa Highway, Ojai, California 93023 Telephone (805) 646-1401 Facsimile (805) 640-2204

RESPONSE: Extension cords were removed from the offending areas and at this time no extension cords are in use in the facility.

6. There were no occupancy signs on the shower room doors, though we observed no improprieties, this could become a privacy issue for some residents.

RESPONSE: Staff continue to knock and wait for permission to enter when shower room door is closed. Privacy shower curtains are in place and used to further assist in assuring residents are not exposed. We are considering adding signage according to resident council recommendations.

7. There was a wasp nest beginning under the eaves in the corner of the patio.

RESPONSE: The wasp nest has been removed. We continue with a contracted exterminator who visits and inspects our building two times monthly and as needed in addition.

8. There was an unsecured ladder by the kitchen exit.

RESPONSE: Unsecured ladder was noted and placed in secure position prior to Operations Guardians team exit on August 6.

9. There were broken tiles in the shower room near the doorway.

RESPONSE: Broken tiles have been repaired.

10. The utility storage rooms in the rear of the facility lack locks on the doors, and contained cleaning chemicals.

RESPONSE: Locks have been installed on the utility storage rooms and rooms are now locked whenever appropriate attendant is not present.

11. There were two sliding door screens that were off track.

RESPONSE: Sliding door screens are occasionally bumped by the wheelchair of residents. No repair was needed. Staff continue to monitor screen doors and they are placed back on track when problem is found.

12. The Fire Inspector noted several Fire Department violations that she itemized in her inspection report.

RESPONSE: The facility has noted a compliance date of August 20, 2002 for all violations found in the Fire & Life Safety Inspection. Upon reinspection on August 23, 2002, all violations were cleared.

Thank you for your assistance in making this a more safe environment for our residents. We found your visit helpful and informative.
If you wish further information regarding any of the issues addressed here feel free to write or call me at (805) 640-2280.

Sincerely,

Marilee J. Sherman, R.N.
Director of Nursing
Continuing Care Center

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

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INSPECTION REPORT SUMMARY #109

Cindy Cordon, Administrator
Glenwood Care Center
1300 North C Street
Oxnard, California 93030

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Glenwood Care Center, in Oxnard, on August 7, 2002. The team identified the following issues:

Care Issues

1. Some residents complained about the staff at night not responding in a timely manner to call lights and a lack of sufficient staffing at night.

2. PRN medications administered did not always have the reason for the administration documented and frequently lacked the result of the administration.

3. The physicians using the services of a nurse practitioner need to document verification that they are reviewing the notes of the nurse practitioner by reading, and then adding their initials and the date of the review to the bottom of the notes.

4. The staff is not filling out the weekly nurses' notes checklist.

5. Some residents' annual history and physicals lacked interim history and complete physical findings documentation. The annual physical has not been completed on resident #02-34-02 ([redacted]K.) since 02/01.

6. Resident 02-34-03 ([redacted].G.) is receiving Robitussin DM at bedtime (1 to 2 Tablespoons). This is a high dosage, and is contraindicated when the resident is also receiving Restoril. This needs clarification through the resident's doctor and

the pharmacist.

7. We noted that multiple residents lacked name bands, which is hazardous when passing medications and providing treatments. It also does not allow for the proper procedures to be followed when passing medications. One armband was found on the window ledge of a shower room and another was found on a table in the activity room. Both residents were located and their armbands were missing.

Environmental

8. There were soda and snack machines on the patio that allow for unsupervised access by residents who may be on sugar and sodium restricted diets, or who may have swallowing difficulties. We suggest placement of these machines in a more supervised area to promote resident safety.

9. The treatment cart on station two was unlocked and unattended, and contained medicated ointments. There were used gloves found on window ledges, on top of soiled linen containers, and on the floor in various location throughout the facility.

10. In the kitchen there were improperly stored bread and zip-lock bags of moldy bread in the pantry.

11. There were moldy tomatoes found in the uncovered containers in the walk-in refrigerator in the kitchen.

12. In the kitchen refrigerator there was an uncovered bowl of cut up fruit with the spoon left in it.

13. Weatherstripping is needed in some places on the exterior doors to prevent flies from getting into the facility.

14. There was an uncovered light bulb in the shower room above the door. This could be hazardous if the light bulb were to break.

15. The drain cover in the male shower room was bent and loose, which could be hazardous to any resident using the shower.

16. They left the soiled linen containers uncovered in the soiled linen closets. Staff was observed adding dirty linen to the containers and not closing the lids.

17. The sprinkler head in the storage closet by nurses station one does not have proper clearance from the objects being stored.

Administrative

18. The team discovered there was an incident of theft of Vicodin suspected which they had not reported to any law enforcement agency.

19. Residents' property inventory records were not updated in a timely manner.

20. Some residents' property was not properly labeled.

21. Residents complained about food being served cold, when it should have been hot.

22. Review of the personnel files revealed that medical files were missing on half the records reviewed.

Staffing

Several dates of patient care staffing records reviewed by the team did not meet the minimum required 3.2 hours per patient day.

Fire

a. Dining room exit doors obstructed by table.

b. Fire extinguisher at nurses' station #2 mounted too high.

c. Some exits partially obstructed by carts and equipment temporarily placed there.

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INSPECTION REPORT SUMMARY #110

Karen Smith, Administrator
Pleasant Care Convalescent-Napa
2465 Redwood Road
Napa, California 94558

Number of beds: 62

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Pleasant Care Convalescent, located in Napa, on August 13, 2002. The team identified the following issues:

Care Issues

1. Team members observed that they did not properly pull residents up in their beds to eat, although they had elevated the head of the beds.

2. The resident in room 119, bed C was noted to be lying in bed naked, with the privacy curtain pulled to block her from view from the hallway. However, the bed is by the window and the window curtain was open, allowing full view of the resident by anyone walking by the window.

3. There was a moderate odor of urine noted in the resident areas, suggesting a lack of proper changing of the residents, proper clean up of the residents and/or proper storage of soiled linens.

4. The medical chart review showed that the licensed staff is failing to document pressure sores properly and completely, bruising and other injuries, with detailed descriptions, location, and size.

5. The weekly skin care sheets were not up to date in most of the records reviewed, with the last entry in most of the records being 7/28/02.

6. The medication administration records lacked signatures for all the nurses' initials.

7. The short term care plans were not being followed or lacked documentation in the medical record that the care was being done. For example resident [redacted].T. fell on 7/12/02 and it was in the care plan to check his vital signs every shift for 72 hours. There was no documentation showing this was done every shift as planned.

8. Residents' annual history and physical exams are not being done in a timely manner. Some are as much as three years overdue. Some physical exams lack physical findings to show that any examination took place at that time.

9. Dr. C. is not making monthly visits as required.

Environmental

10. The medication carts and treatment carts were found outside the nurses' station unlocked and unattended.

11. We observed the medication room open and unattended.

12. The front utility room was found propped open with an open drawer pressed into a carved out area of the wooden door. The room was unattended and contained razors and chemicals.

13. Later in the day the utility room door was closed, but the key had been left in the lock, defeating the purpose of locking the door.

14. While walking through the facility, the team noted that at least three residents' urinals had been left on their overbed tables, two of which contained urine.

15. The resident in room 117 has an order to wear a boot on the left heel, but it was nowhere in sight.

16. Several call bells were on bedside tables or on the floor and out of reach of the residents.

17. The door to the heating control room was unlocked. The room poses a hazard to wandering residents. The sink faucet in this room was leaking badly.

18. There were occupancy signs on the shower room doors. However, the staff is not using them when they take a resident in or out of the shower rooms.

19. There were used gloves found on the floor of the shower rooms and in a bathtub.

20. There were dirty linens left in shower rooms.

21. Several soiled linen carts were overstuffed and were not properly covered,

creating an odor of urine in the hallways.

22. Several wheelchairs were found to have badly cracked armrests, backs and seats, which could tear the fragile skin of the residents.

23. In the residents' rooms, we noted that staff was failing to properly close drawers and closet doors creating a hazard for residents walking in their rooms.

24. Also in the residents rooms were bed cranks that were not being properly replaced after they raise the head or foot of the bed. They extend beyond the bed rather than being pushed under the bed, creating a hazard.

25. There was floor damage noted near the entrance to room 114.

26. The hallway handrails were gouged in several places and extremely rough, which could tear fragile skin. They need to be sanded and refinished.

27. The braces to the handrail by the rear exterior door and the one between room 118 and 119 were broken, and need to be replaced immediately to prevent falls by residents who are already unsteady on their feet.

28. One supply closet that contained activity supplies also contained a cart of nail care supplies, including polish remover and scissors that should be in a secured location.

29. The lobby has a power cord connected to the fish tank and an electrical outlet in the floor that is hazardous to anyone walking in the area.

30. The exterior doors are lacking proper weatherstripping to prevent flies from entering the facility.

31. The door to the residents' patio was propped open allowing flies into the facility. There is also a bush by the door that had several bees hovering around it. The team noted several staff pass the door without anyone closing it.

32. There was food on the concrete of the patio, which caused one team members to slip, and would be hazardous to residents who are less stable.

33. There were two tables on the patio that were both broken and in such bad condition that they could easily cause injury to residents.

34. The benches on the patio have several gouges in them, exposed nails sticking out and are very rough. They need sanding and refinishing.

35. There were both snack and soda vending machines in an unsupervised corner of the residents' patio. This could be potentially hazardous to residents on low sodium or low sugar diets or those who may have swallowing difficulties.

36. There was an area of slime and moss growing on the ground near a patio door that

could be hazardous.

37. There were several cables hanging from the roof on the residents' patio near one of the doors.

38. There was a step ladder propped against the building on the patio, which had been left unattended and would allow access to the roof.

39. There was an unsecured ladder attached to the back of the building that would allow easy access to the roof by wandering residents.

40. In the kitchen freezer there were cups of improperly covered and undated ice cream.

41. In the walk-in refrigerator there were several containers of leftovers that they did not cover and were undated.

42. There were several containers of nearly empty laundry and cleaning chemicals left outside the laundry room door.

43. There was a car battery left out in the rear of the building.

44. The tree branches at the rear of the building are beginning to hang on the phone and electrical wires leading to the facility.

45. There was a box of wires and cable connections hanging from it near the roof at the rear of the building.

Administrative

46. Residents complained that they did not serve the food at the proper temperature and that they sometimes had trouble reaching their food trays.

47. Residents complained about the lack of staff at night and that they are slow to answer call lights after dark.

48. Residents' personal property inventory records are not up to date.

49. 50% of the personnel files reviewed lacked an up to date license or certification, and lacked documentation that the administration had verified that the license/certification was current.

50. 80% of the personnel files reviewed lacked documentation showing that TB testing had been done per regulation and that a physical examination had been done.

51. 50% of the personnel files reviewed lacked documentation regarding references being checked.

Staffing

Staffing for all the days reviewed was below the minimum required 3.2 hours per patient day. Weekends were especially low, remaining well below 3.0.

Fire

a. The exit door to southeast portion of the facility was tied shut with a bed sheet due to a broken door latch/lock mechanism.

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INSPECTION REPORT SUMMARY #111

Palm Springs H ealthcare & Rehab Center
G. Scott Gilllis, LNH A, Administrator
277 S. Sunrise Avenue
Palm Springs, CA 92262

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On August 20, 2002, the Operation Guardian team conducted an inspection of Palm Springs H ealthcare & Rehabilitation Center. The team identified the following:

Care Issues

1. In some records, the physician had failed to sign orders.

2. Some records lacked a history and physical by the doctor.

3. Some visits are not being made by doctors according to Title 22 regulations.

4. Resident 36-01 was being administered oxygen without a physician's order. The staff also is using a pulse oximeter without an order or parameters. Further, there was a concern about this resident being placed on Restoril without a proper assessment regarding the diagnosis of insomnia.

Environmental

No problems were detected

Administrative

5. There were no substitution menu posted at the nurses station, and the kitchen also lacked a substitution menu. The kitchen cook was unaware of the necessity of

having this posted. No problems were detected

Staffing

No problems were detected

Fire

No problems were detected

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INSPECTION REPORT SUMMARY #112

Gary Little
Administrator
Premier Care Center
2990 E. Ramon Road
Palm Springs, CA 92264

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On, August 21, 2002, the Operation Guardians team conducted an inspection of Premier Care Center. The following are the findings from that inspection:

Care Issues

1. With respect to chemical restraints, resident 37-01 was prescribed Morphine sulfate for combativeness. Resident 37-02 was prescribed Zyprexa without a clear indication. There was no psychological assessment in the chart that stated the patient was psychotic.

2. The medical director's charts lacked signed orders and the progress notes were inadequate.

3. Some records lacked fall assessments or skin assessments.

Environmental

4. Complaints regarding the food temperature are ongoing. Resident council minutes reflect patient complaints, and interviews with residents on 8/21/02 supported our finding that the problem continues. The facility was noted using uncovered tray carts that may not provide adequate heat containment for food transfer.

5. Fire extinguisher number 6 was not secured and was accessible to patients.

6. An RN left her medication cart open and unattended.

7. Moldy grout was noted in the shower stall.

8. The hand-washing sink in the kitchen lacked adequate hot water.

9. The paper towel dispenser for the hand-washing area was empty.

10. The light bulb in the walk in a refrigerator was burned out.

11. Two kitchen assistants lacked hair nets and were working in the open kitchen environment.

Administrative

No problems were detected

Staffing

No problems were detected

Fire

No problems were detected

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INSPECTION REPORT SUMMARY #113

Dane Rank, Administrator
Harbor View House
921 S. Beacon Street
San Pedro, CA 90731

Number of beds: 83

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On August 27,2002, the Operation Guardians team conducted an inspection of, Harbor View House, located at, 921 S. Beacon St., California. The team identified the following issues:

Care Issues

1. The facility failed to get a repeat Prolactin level for resident 38-A and they failed to get a CT scan with contrast or MRI.

2. Resident 38-A was receiving both Haldol and Risperidol. There was no discussion in the clinical record as to why.

3. Resident 38-B was noted to have had TB as a child. He was given two annual TB tests. Each was negative. There was no review to assess accuracy of the history as taken. There was no chest xray on record.

4. On 4/11/01, resident 38-B's physician wrote a letter to the facility/dentist requesting that they make sure the resident has his dentures in his mouth. The resident is losing weight because he is not able to chew his food.

5. Resident 38-B had an acknowledged skin condition on his legs, arms, and trunk. The physician for this resident was unaware of this.

Environmental

No problems were detected

Administrative

No problems were detected

Staffing

No problems were detected

Fire

a. Provide and maintain a fire alarm system in accordance with the LA Municipal Code.

b. Provide and maintain approved automatic door closers on the fourth floor at stairwell #4.

c. Maintain fire hose in readiness for emergency use at all times. Third floor and second floor northwest hallway need repairs to the hose and/or the cabinet.

d. Restore fire assembly door to original operating condition on second floor Art Gallery.

e. Remove all items which block, obstruct, or diminish the required width of exit the door leading to stairwell from the Art Gallery.

f. Repair or replace panic hardware.

g. Provide approved smoke detectors on the second floor, rooms 200 and 207.

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INSPECTION REPORT SUMMARY #114

Sister Sharon
Director of Nursing Services
Little Sisters of the Poor
2100 South W estern Avenue
San Pedro, CA 90732

Number of beds: 34

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On August 28, 2002, the Operation Guardians team conducted an inspection of, Little Sisters of the Poor, located at, 2100 S. Western Avenue, San Pedro, CA 90732. The team identified the following issues:

Care Issues

1. The facility has a high incidence of unobserved falls.

2. Notes in nursing charts are short, with some totally illegible.

3. Physicians' progress notes were incomplete.

4. A resident was receiving both HCTZ and Lasix with no explanation.

5. Many care plans lacked detail. Some were not completed.

Environmental

6. Two shower rooms had regular bars of soap.

7. One shower had a container of deodorant (roll on type), bar soaps, and a shower cap.

Administrative

8. The facility has failed to properly track TB testing of staff members.

No problems were detected

Staffing

No problems were detected

Fire

No problems were detected

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INSPECTION REPORT SUMMARY #115

Mary Hart, Administrator
Brookvue Care Center
13328 San Pablo Avenue
San Pablo, California 94806

Number of beds: 108

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Brookvue Care Center, located in San Pablo, on September 3, 2002. The team identified the following issues:

Care Issues

1. The weekly nurses' notes lacked detail.

2. Descriptions of wounds lacked complete measurements and detailed descriptions.

3. The medication and treatment administration records lacked signatures for the nurses' initials. These should be done as soon as the first medication is given.

4. Several physicians are not visiting on a regular monthly basis.

5. The physicians' orders do not always have proper notation by the licensed staff.

6. One resident was observed by the team being wheeled down the hall to the shower by a CNA who had not properly covered the resident. Her back and buttocks were exposed.

7. The team observed another resident being showered with the shower door left open, leaving the resident exposed.

8. The station one treatment cart was found to be unattended and unlocked.

9. The station three medication room contained expired medications.

Environmental

10. There was no soap or paper towels available in the staff restroom.

11. The hallway floors were in need of wet mopping.

12. The janitor/housekeepers' room was unlocked and contained chemicals.

13. There were medications and chemicals in the unlocked utility room, which had a sign on the door stating that the door was to be locked at all times.

14. The hallway handrails were dirty and sticky.

15. There was an extension cord being used in the laundry room.

16. There was mildew in the corners of the shower stalls in all the shower rooms.

17. There was trash on the floor around the kitchen stove.

18. There was uncovered and undated food in the refrigerator in the kitchen.

19. There was a leaking faucet in the kitchen.

20. Diapers and other items are stored in closets too close to the sprinkler heads.

21. There were multiple bent and torn window screens, including one in the kitchen.

22. There is severe doorway damage in shower room four.

23. Dirty linen was not properly stored in closed linen containers.

24. The bench in the courtyard is in need of repair.

25. The gutters had rusting down-spouts, many with holes rusted through.

26. There was wall damage on the side of the building.

27. The maintenance storage room was left unattended, open and contained improperly stored paints.

Administrative

28. Residents' personal property inventory sheets were not up to date, and residents' personal property was not properly marked.

Staffing

Below minimum daily requirements.

Fire

Unavailable

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INSPECTION REPORT SUMMARY #116

Linda Joseph, Administrator
Muir Senior Center
1790 Muir Road
Martinez, California 94553

Number of beds: 96

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Muir Senior Center, located in Martinez, on September 4, 2002. The team identified the following issues:

Care Issues

1. Dr. [redacted]M.'s history and physical examinations lack documentation of physical findings and he is not responding to the pharmacy consultant's recommendations.

2. The call lights on station two have not worked since Labor Day, according to residents' complaints. The current failure of the call lights was verified by team members.

3. The medication administration records lack signatures for some of the nurses' initials. These should be done as soon as the first medication is given.

4. Nurses notes lacked details in documentation of injuries and the follow up of appropriate care.

5. Care plans are not always up to date and are incomplete.

6. The team noted that the resident in room 21 was being assisted in dressing while her room door was left open. Her privacy curtain and bedroom window curtain were also left open. Residents have the right to privacy.

7. There was a faint odor of urine when the team entered the facility, followed by a stronger odor of insecticide in the back halls.

Environmental

8. There were large numbers of dead ants in the freezer, along with frozen food. Ants were also found alive in the dishwashing area, in packages of cookies, and on the pantry shelving.

9. There was a leak in the pre-soak line in the kitchen dishwasher.

10. There was a torn window screen on an open window in the kitchen.

11. Freezer #2 in the kitchen had a worn gasket and needs to be replaced.

12. There was a leaking faucet in the kitchen.

13. There was rust and large number of ants found in the shower rooms.

14. There is floor damage in the bathroom of the restorative dining room.

15. The exterior doors are in need of weatherstripping.

16. There is mildew growing through the caulking in the shower rooms.

17. There was trash left on the shower room floors, along with dirty linen.

18. There is a leaking faucet and ants in the medication room of station two.

19. The fire extinguisher on station two needs recharging.

20. There are multiple wheelchairs with torn armrests, seats, and backs.

21. There are candy and soda machines in the residents dining room, allowing unsupervised access to residents on specialized/restricted diets.

22. The sliding door to the residents dining room does not close properly.

23. The wooden fascia on the eaves of the building is rotting and needs replacing.

24. The drain cover in shower room #2 is bent and loose, and hazardous to residents using it.

25. Multiple sliding door screens are bent, torn, and/or off track.

26. The yard in the back of the facility is currently unsafe for residents to wander. There are multiple gopher holes and the fencing is falling down.

27. There is a lot of trash strewn around the grounds of the facility.

28. There was heavy equipment and paint left in an unlocked shed.

29. There was a garden hose left out and improperly stored.

Administrative

30. The personnel files lacked documentation regarding reference checks on employees.

31. Residents' rights were not posted anywhere in the facility at the time of the inspection.

32. Residents' personal property inventory records were not up to date and the residents' property was not all properly marked.

Staffing

Below minimum daily requirements.

Fire

a. Exit doors shall be openable from the outside in room #7, therapy, 19 & 20.

b. Mat blocking door at east end by room 40.

c. Remove combustibles under ramp at southeast end.

d. Repair breached ceiling in basement/heater room.

e. Repair cross-corridor doors for rooms 33 & 34. They do not latch.

f. Remove storage from in front of exterior door at room 39.

g. Repair storage door at room 22.

h. Dietary service door does not close and latch.

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INSPECTION REPORT SUMMARY #117

Ben Hughes, Administrator
Evergreen Healthcare/Encinitas
900 Santa Fe Drive
Encinitas, CA 92024

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

Thank you for participating in our unannounced inspection of your facility on September 10, 2002. The Operation Guardians team identified the following issues, most of which we discussed with you during our exit of your facility.

Care Issues

1. From the review of approximately eight resident records we noted that physicians are failing to sign off on their orders and are not regularly updating their progress notes.

2. Abnormal lab values were not being followed up on in a timely fashion.

3. At least one clinical record revealed that the physician's orders for medication lacked a route of administration.

4. Resident council minutes reflected that the facility is not following up on resident concerns. On 6/02, two residents complained that their incontinent briefs leaked and did not provide adequate protection during the night. Both stated they were soiling not only their night clothes, but bed linens.

5. Residents complained on 5/02 that the facility was holding the resident council meetings at a time when many participants were taking afternoon naps and missing the meetings. A review of the minutes did not show where they had

changed the meeting times.

6. We documented a resident as receiving regular treatments with Albuterol and Flovent. No diagnosis was found to support the use of these inhalers. This resident also lacked orders for regular Digoxin levels.

Environmental

7. The resident in room 63 had tattered curtains that we could see from the patio area of the facility. Below this window the concrete foundation had a large hole in it.

8. Room 70-75, a four-bed ward, which was occupied, had no privacy curtains.

Administrative

9. A vacant resident room held a large beige recliner that appeared to belong to a resident no longer residing at the facility. The facility stated that a resident's family donated it to them. However, you did not provide, at the time of our exit, any proof to substantiate your claim.

Staffing

No problems were detected

Fire

a. Provide five year service on sprinkler system and display record on riser.

b. The kitchen hood system needs to be serviced and tagged.

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INSPECTION REPORT SUMMARY #118

Pam Ferris, President/CEO
Seacrest Village
The Dorothy and Joseph Goldberg Healthcare Center
211 Saxony Road
Encinitas, CA 92024

Number of beds: 58

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

Thank you for participating in our unannounced inspection of your facility on September 11, 2002. The Operation Guardians team identified the following issues, most of which were discussed with you during our exit of your facility.

Care Issues

1. During the initial walk through tour, and approximately an hour later, at least two residents were noted to have their call lights out of reach and in need of assistance.

Environmental

2. Access to the payphone was blocked by broken patient care equipment.

3. The shared bathroom in room 30 contained an unlabeled bedpan that was soiled with a brown substance.

4. The shared bathroom in room 31 contained a toothbrush holder with four different toothbrushes, none of which were labeled. This was a two-resident room.

5. The housekeeping closet next to room 33 was found unlocked. A bottle of nail polish remover was found lying on the floor.

6. Two EZ stand lifts were noted to have large amounts of food particles and other

debris at their base.

7. The century tub in the Tub room nearest the nurses' station had a leak from somewhere behind the tub itself, causing the tile to be wet. The hose was missing from the front of the tub and water leaked from there. Inside the tub itself was numerous personal items which were unlabeled.

8. The toilet in the Tub room was noted to be soiled with a brown substance. On a sink in the same vicinity, a dirty comb was noted. An electric hair-dryer was noted plugged in and lying on a small shelve above the sink and near the tub.

9. The privacy curtains in room 21 were noted to be tangled and would not progress on the runners and close properly.

Administrative

No problems were detected

Staffing

No problems were detected

Fire

Unavailable

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INSPECTION REPORT SUMMARY #119

Robert Garber, Administrator
Manorcare H ealth Services
74350 Country Club Dr
Palm Desert, CA 92260

Number of beds: 178

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

Thank you for participating in our unannounced inspection of your facility on September 17, 2002. The Operation Guardians team identified the following issues, most of which we discussed with you during our exit.

Care Issues

1. There are a large number of falls that occur in the facility associated with poor monitoring of patient needs and the answering of call lights.

2. There are a large number of skin tears in the facility associated with improper handling of residents during transfers and patient care.

Environmental

3. There were numerous pieces of patient care equipment that needed cleaning.

4. The team found numerous L atex gloves throughout the facility that were discarded on the floor.

5. A resident room had large smears of what appeared to be feces on the floor near the bed.

6. The shower room had one stall that appeared to have a human stool on the floor.

7. The kitchen area was unsanitary and disorganized.

Administrative

No problems were detected

Staffing

No problems were detected

Fire

No problems were detected

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INSPECTION REPORT SUMMARY #120

Carole M. L illis, Administrator
Monterey Palms H ealthcare Center
44610 Monterey Avenue
Palm Desert, CA 92260

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

Thank you for participating in our unannounced inspection of your facility on September 11, 2002. The Operation Guardians team identified the following issues, most of which we discussed with you during our exit of your facility:

Care Issues

1. A resident was seen calling for help and in a position in her bed that could have led to a fall. No one responded to her calls for help and her call light was out of reach. This resident has suffered numerous falls and had fallen and fractured her hip in June.

2. An alleged sexual assault occurred at the facility. DH S did an investigation and did not issue a citation. H owever, you did not call law enforcement and any proper investigation into the allegation was undertaken.

Environmental

No problems were detected

Administrative

3. You documented in the theft/loss logs that a resident had complained that someone had stolen her necklace and ring. There was no follow up by the facility to reimburse, investigate or report her loss to law enforcement.

4. B etween the year 2000 - 2001, there appeared to be a pattern of thefts in the facility that would always occur when a patient died. The patient's family would complain that certain items of jewelry or money or wallets were missing. For 2002, it seems that this pattern, based on the theft loss log, has not repeated. This was brought to your attention for further investigation.

Staffing

No problems were detected

Fire

U navailable

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INSPECTION REPORT SUMMARY #121

Joseph A. Aguiar
Executive Director
Valencia Palms Nursing Center
82-262 Valencia Ave.
Indio, CA 92201

Number of beds: 68

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

Thank you for participating in our unannounced inspection of your facility on October 8, 2002. The Operation Guardians team identified the following issues, most of which were discussed with you during our exit of your facility:

Care Issues

There were no problems detected

Environmental

1. A large depression in the front asphalt caused a team member to trip.

2. The ceiling fan in the entrance is low enough to present a hazard to a tall person, or equipment movement.

3. The driveway, asphalt in the rear of the facility was crumbling away.

4. The storage shed was crowded and cramped with miscellaneous equipment, making it difficult to reach emergency food and water stored in the same area.

5. A barbecue grill with a propane tank was stored in this shed.

6. A gas can and a lawn mower with a gas tank was also stored in this shed.

7. We noted moldy oranges and onions in the kitchen dry storage.

Administrative

8. Your employees are not properly screened or tracked for tuberculosis.

9. The Medical Director is not following up on employee physicals.

Staffing

No problems were detected

Fire

a. Change all fire sprinkler heads for hood and duct cooking operation.

b. Ensure dryer vent near single water heater room is moved away from wood combustible enclosure per the mechanical code.

c. Remove pigtail electrical connection in dual water heater room and provide permanent wiring per national electrical code.

d. Discontinue combustible storage under eave on north east corner of building.

e. Ensure all storage in storage rooms remain 18" below sprinkler heads.

f. In storage room at northeast corner of building, repair ceiling hole.

g. Ensure self closure on fire doors to kitchen and laundry room are adjusted so they close and latch secure.

h. In the storage room next to room 20, remove top shelf blocking fire sprinkler head.

i. Remove gasoline cans, gas operated appliances from storage room at northeast corner of building and provide a separate detached storage shed.

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INSPECTION REPORT SUMMARY #122

Joseph A. Aguiar, Executive Director
Indio Nursing and Rehabilitation Center
47-763 Monroe Ave
Indio, CA 92201

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

Thank you for participating in our unannounced inspection of your facility on October 9, 2002. The Operation Guardians team identified the following issues, most of which were discussed with you during our exit of your facility.

Care Issues

No problems detected.

Environmental

1. A ceiling fan in the immediate entry was hung low enough to cause concern for the safety of visitors.

2. The walk in freezer system had a leak that allowed an unidentified liquid to splatter onto food and surfaces in the freezer.

Administrative

3. The management staff oversees at least two facilities, one of which may show signs of neglect in some areas. The management team was cautioned regarding spreading themselves too thin.

4. Employee physicals are not being maintained and monitored appropriately, especially with respect to TB screening.

Staffing

No problems were detected

Fire

a. Chain link gate located on the west side of building shall not be locked with any device that would require special knowledge or effort to prevent egress.

b. Proof of proper permits will be required for the construction and installation of the patio located on the westside of building.

c. The inside curb of the vehicle path on the north, west and south sides of the building shall be a fire lane.

d. Door leading into the general storage room shall be labeled “fire door - please keep close.”

e. Fire door between laundry & folding room, fire door between dining room & main hallway, exit door at the end of wing 400 and fire door to tide pool room will require adjustment.

f. Fire door in hallway leading to kitchen and door from dining room to main hallway will require the smoke seal gaskets to be replaced.

g. Fire door leading into soiled laundry room will require recertification or replacement due to change of placement of door hinges.

h. Current license care facility permit will be required.

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INSPECTION REPORT SUMMARY #123

Jennifer Pennington, Administrator
Willow Creek Healthcare Center
650 W. Alluvial Avenue
Clovis, California 93611

Number of beds: 159

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Willow Creek Healthcare Center, in Clovis, on October 16, 2002. The team identified the following issues:

Care Issues

1. The team noted that staff was not answering resident call lights in a timely manner. Multiple staff, both CNAs and licensed, were seen walking past rooms with call lights on and they failed to check on the needs of the residents. When asked by a team to please check on a resident they told the team member that it was not their assigned room. One staff person did enter the room at the team member's request, but told the resident she was busy and would be back in a few minutes. She did not return.

2. Staff brought breakfast trays out in one area at 8:05 a.m. and we noted that they were still feeding those residents at 9:15 a.m., and that food was cold.

3. A team member observed licensed staff passing medications and not initialing the medication on the medication administration record until they had passed all meds. This is contrary to acceptable practice.

4. Some signatures for the initials of the licensed staff who administered the medications were missing from the medication administration records.

5. Medication and treatment carts containing medicated ointments were found in the hallways unattended and unlocked.

6. We noted that multiple residents had clean, but exceptionally long and frequently ragged toenails.

7. Dr. D. is not properly documenting his visits. He is photocopying the previous progress note with his signature, changing the date and sometimes adding some minimal notes. Residents complained that he is not seeing them monthly. Some of his annual history and physicals need updating.

8. Dr. S. is not making monthly visits to his patients.

9. Many charts reviewed lacked documentation of the residents' rehab potential.

10. Several residents complained that they have difficulty getting dietary requests fulfilled, even if they are allowable by their physicians. They also complained that they frequently get their meals served late and the food is cold.

11. Residents complained about dinner being served at or after 6:00 p.m. and they are very hungry by that time.

Environmental

12. There was a strong odor of urine noted in the hallways of the facility.

13. There were several windows and sliding door screens bent, torn and/or off-track. This could allow flies and other flying insects into the facility to contaminate wounds and residents' food.

14. The sprinkler system standpipe indicated that the last inspection was completed on 3/20/97. This must be done at least every five years.

15. There were substantial amounts of trash strewn outside the facility in the yard and plant areas.

16. There was a leaking faucet noted outside in the rear of the facility.

17. There were multiple sink holes noted outside the facility in areas that are accessible to the residents. We discussed this with the administrator and he told the team that this is a known problem that is due to a leaking sprinkler system.

18. There was a used glove found outside on the ground near the rear of the courtyard area, which is an infection control problem.

19. There was heavy cleaning equipment outside near the courtyard left unattended in a resident accessible area.

20. The building's attached ladder had an appropriate guard. However, it was unlocked and had been left unattended, which could be hazardous to wandering residents.

21. Several exterior doors need the weatherstripping replaced as there are gaps large enough for flies to enter.

22. The front recreation room is being used for storage, but is still open to residents for use.

23. We noted that some hallways were obstructed on both sides, or on one side extending beyond the middle of the hallway. This causes a hazard to residents ambulating the hallways.

24. In the kitchen, the floors under the storage shelves are badly in need of sweeping.

25. There was a leaking faucet in the kitchen's sanitizing and disinfecting sink.

26. There was a soda vending machine in an unsupervised area in the recreation room. This is a potential hazard to residents who are confused and on sugar and/or sodium restricted diets.

27. Many interior doors in the facility do not close properly.

Administrative

28. While reviewing the personnel files, we noted that most of the files lacked documentation that your facility checked the applicants' references.

29. The personnel file of CNA [redacted] K. shows documentation of TB testing administered 3/28/02, but fails to document any results for the test.

30. The personnel files of [redacted] C., [redacted] G., and [redacted] B. lacked documentation of any TB testing.

31. The personnel file of [redacted] C. lacked documentation of an up to date certification.

32. The personnel file of [redacted] B. lacks documentation of a physical exam. The staff questionnaire is the only thing present.

33. The personnel files of [redacted] M. and [redacted] C. both lack documentation of any TB testing and lack a physical examination record.

Staffing

34. Staffing levels reviewed by the team were below the required 3.2 hours per patient day on three of the four days reviewed.

Fire

a. Smoke seal torn on fire door just north of recreation room in hallway.

b. Adjust smoke seal fire door just west of main entry going into west hallway.

c. Fire door just east of room 210, north side door does not close properly.

d. Smoke seal torn on fire door just north of room 300.

e. West side fire door smoke seal torn going into therapy room.

f. West side fire door going into therapy room not locking on bottom lock.

g. West side fire door going into therapy room door closure magnet loose.

h. Discontinue use of extension cord in Rehabilitation office.

i. Door just north of Rehabilitation office going outside is not closing properly.

j. Left side exit sign bulb burnt out on exit sign at west wing by main entrance.

k. Doors just south of janitor closet northwest wing not closing properly.

l. A clear width of 30 inches shall be maintained for the face of all electrical panels.

m. Fire door smoke seal torn going into the assisted dining room.

n. North side fire door not locking going into the administrator's office areas.

o. Smoke seal torn of west side door going into administrator's corridor.

p. Bottom lock not latching on west side door going into administrator's corridor.

q. Exit light bulb burnt out going out to patio.

r. Both bottom latches not locking going into dining room.

s. West exit door going outside from dining room will not open.

t. Both door locks not latching just south of business office.

u. South side emergency door going into west wings not latching.

v. Emergency exit light bulb burnt out going into west wing from the south side.

w. Discontinue use of extension cords in business office.

x. Discontinue use of extension cords in records office.

y. Smoke seal torn of north side emergency door going into social dining room.

z. Emergency door on west side of north doors going into social dining room not locking.

aa. Emergency door seals torn going into station one on south end.

bb. Sprinkler system riser shows five year system inspection past due.

cc. Repaint all curb faces fronting the access red. The words “NO PARKING EMERGENCY ACCESS” shall be painted thereon in three-inch (3") white letters, every seventy-five (75) linear feet of travel.

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INSPECTION REPORT SUMMARY #124

Jennifer Pennington, Administrator
Valley Health Care Center
4840 E. Tulare Ave.
Fresno, California 93727

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On October 17, 2002, the Operation Guardians team conducted a surprise inspection of Valley Health Care Center at 4840 E. Tulare Ave., in Fresno, California. The team identified the following issues:

Care Issues

1. The nurses' notes lacked details of bruising, such as exact sizing and color with a more exact location. This was also evident for other injuries noted.

2. The medication administration records lacked signatures for all nurses' initials who pass medications.

3. There was a lack of ongoing assessments on residents problems.

4. Care plans did not clearly state the goals and objectives and did not always match the current status of the resident.

5. Progress notes written by Dr. D. are photocopies of the previous month with a new date written in black ink. Even the signature had been photocopied. This is an unacceptable practice.

Environmental

6. There was a mild odor of urine noted when the team entered the facility.

7. There were two wheelchairs with slightly torn armrests that could cause skin tears to fragile elderly skin.

Administrative

8. Personnel files were incomplete. Personnel left stacked TB testing and physical exams carelessly on a desk and not filed in the proper file. Certifications and licenses of the staff were found in several places; a binder, stacked on the desk, or sitting on the floor by the desk. You must properly file all records.

9. The DSD found the unreadable TB test identified to the staff by the team and they sent a copy to this office after our inspection.

Staffing

Staffing levels were below the minimum required for all days reviewed by the team.

Fire

unavailable

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INSPECTION REPORT SUMMARY #125

Ms. Pollyanne Frank, Administrator
Apple Valley Care Center
11959 Apple Valley Road
Apple Valley, California 92307

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Apple Valley Care Center, located in Apple Valley, on November 20, 2002. The team identified the following issues:

Care Issues

1. Most of the care plans reviewed were incomplete and did not adequately address the issues of the particular residents.

2. The history and physical done on resident [redacted] P. (02-50-09) indicates that her ear exam was negative, but does not address the fact that she is deaf.

3. Resident [redacted] C. (02-50 08) shows a significant weight loss recently which lacks dietary follow up and assessment.

4. Resident [redacted] W. (02-50-07) shows a weight loss of 8.6 pounds in two months, but there is no physician notification documented.

5. The history and physical dated 11/11/02 does not document any physical findings. “See attached” with nothing attached is inadequate.

6. The history and physical examinations done by Dr. [redacted] S. lack an interim history and also lack physical findings.

7. It was noted on several occasions during the inspection that staff was slow to

respond to residents' call lights. Many staff were observed walking by rooms with call light on without checking on the needs of the resident.

Environmental

8. There was a large crack noted in the front of the facility building.

9. There was a large amount of "junk" by the side of the outbuildings.

10. The garden hose in the back of the facility was not properly stored, and could be hazardous to anyone walking in the area.

11. The door from the staff lounge to the outside of the facility was consistently left open, which allows flies into the facility.

12. There was a dirty wash cloth on the floor and a razor left on a shelf in the shower room by the diningroom.

13. There were leaking faucets in the kitchen.

14. The upholstery on some geri-chairs was torn on the armrests and seats.

15. The utility closet by room 206 was not closed properly and contained chemicals.

16. The threshold strip is missing in the shower room by room 211.

Administrative

17. There was missing documentation for some checks in the residents trust accounts.

18. The personnel file of CNA S. lacked an up to date certification, it expired 8/5/02.

19. Some PPD tests were not documented as having been read in the personnel files reviewed.

Staffing

No problems were detected

Fire

a. Provide and maintain exitway lighting at station #2.

b. Repair fire doors in the 300 hall.

c. Replace sign on bell.

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INSPECTION REPORT SUMMARY #126

Gary Bechtold, Administrator
Desert Knolls Convalescent Hospital
14973 Hesperia Road
Victorville, CA. 92392

Number of beds: 126

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Desert Knolls, in Victorville, on November 21, 2002. The team identified the following issues:

Care Issues

1. Upon entering the facility the team noted a faint to a mild odor of urine in the facility hallways, which disappeared shortly after entry.

2. The history and physicals written by Dr. M. were inadequate to substantiate that a physical examination took place. Most said "See attached," but had nothing attached. All lacked physical findings.

3. The medication administration records in the residents' medical records lacked signatures for many of the nurses' initials.

4. Resident [redacted] B. (02-51-09) needs an updated annual history and physical.

5. The care plans of the medical records reviewed were incomplete and in need of updating.

Environmental

6. There were several wheelchairs and geri-chairs which had torn backs, arms and/or seats that could tear the skin of elder residents.

7. There were dirty linens and a used glove left on the floor of the shower room across from room 38.

8. There was damaged concrete on the patio that could be hazardous to residents walking in the area.

9. There was a bent screen on the window of the northeast corner of facility.
10. The sliding door to the patio was consistently left open by staff, allowing flies and other insects access to the facility.

11. There was an open bag of bread in the kitchen.

12. There were sandwiches in the kitchen refrigerator that were not properly dated.

13. The door to the staff lounge was consistently left open by staff.

Administrative

14. Personnel files reviewed revealed that there is no up to date CNA certification for [redacted] G. that expired 4/22/02. There are no certifications in the files of CNAs [redacted] S. and Tina C.

Staffing

No problems were detected

Fire

a. Maintain 18" clearance from sprinklers at all times.

b. Maintain hallways free and clear of obstacles.

c. Have hood system in kitchen reworked to accommodate current appliances.

d. Provide five year certification of sprinkler system.

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KNOLLS WEST / DESERT KNOLLS

Convalescent Hospital

Residential Care

Day Care for Seniors

14973 Hesperia Rd.
Victorville, California 92392
Telephone (760) 245-6477
FAX (760) 245-7296

Guardians Inspection Plan of Correction (P.O.C.)

Regarding current Operation Guardian Inspection on 11-21-2002. The following are P.O.C.'s for areas of concern during your inspection. I realize it is not necessary to give you a written P.O.C., although we would like to take this opportunity to address all the areas of concern.

P.O.C. #1

No Plan of Correction required. DKCH does house multiple residents, up to 125, odors are going to happen due to the normal process of elimination. Although if odors disappear timely, we feel our staff is doing their job. It is when odors linger that we have a problem. We do not believe in masking odors, rather we take care of them with timely cleanings.

P.O.C. #2

A) DKCH will issue letters to M.D.'s who visit our facility RE: adequate documentation, physical exam, disease process, medication's, progress notes and overall condition of residents with importance placed on avoiding repetitive documentation.
B) Medical Records to audit Quality of Entries.

P.O.C. #3

A) In-service Licensed Staff by 02/07/03 and as needed.
B) Medical Records to audit all MARS for signatures.

P.O.C. #4

1) Resident [redacted], annual History and Physical updated by M.D. on 11/27/03.
2) Medical Records to audit every month for annual updates.

P.O.C. #5

A) Care plans reviewed Quarterly, Annually and as needed with C.O.C. Overseen by M.D.S./R.N. Coordinator.
B) Full house audit done every month for timely completion. All in compliance at present.

P.O.C. #6

A) Wheel chairs and Geri chairs washed every month. Those chairs in need of repair will be removed from the floor out of use until repaired by maintenance.
B) Full house observation made and defective, old chairs removed by 2/07/2003. No negative outcome. Related to wheel chairs noted.

P.O.C. #7

In-service C.N.A.'s and Housekeeping by 1/31/2003 and every month for 1 year.

P.O.C. #8

1) Concrete on patio will be patched by 2/28/2003.
2) Intention to completely restore outdoor patio surface under consideration by Administration.

P.O.C. #9

1) Maintenance and Housekeeping in-serviced on timely repair of screens by 1/31/2003.
2) Under Climate Control conditions windows stay closed to decreased the opportunity for pests to enter facility through bent screens and maintain proper temperatures.
3) Screens will be checked by Housekeeping every month and as needed with window cleaning schedule.

P.O.C. #10

Sliding door was stabilized to assure that the door would not be knocked ajar, providing a well and approximate fit for closure by 12/10/2002.

P.O.C. #11

Dietary Supervisor will in-service the Kitchen Staff by 1/24/2003 and as needed.
QA and Administration to oversee outcome.

P.O.C. #12

Dietary Supervisor will in-service the Kitchen Staff by 1/24/2003 and as needed for proper labeling.
QA and Administration to oversee outcome.

P.O.C. #13

Placed sign on Staff Lounge door to keep closed while unattended Eff. 12/12/2002.

P.O.C. #14

Effective date of [redacted] license was 4/22/2002 (not an expiration date). See attached.
Employee [redacted] is not a C.N.A., therefore no C.N.A. license needed.
Employee [redacted] passed C.N.A. test pending license, results approved by D.H.S. for employment.

Please review above P.O.C. for completion of findings. Staff at DKCH will be more than agreeable to assist Inspector's with findings to alleviate wrong findings with employee files.

Sincerely,

Karen A. Irvin, R.N./D.O.N.
01-21-2003

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State of California Department of Justice

Office of Attorney General
Bill Lockyer

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INSPECTION REPORT SUMMARY #127

Velda Pierce, Administrator
San Miguel Villa
1050 San Miguel Road
Concord, California 94518

Number of beds: 190

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of San Miguel, located in Concord, on December 3, 2002. The team identified the following issues:

Care Issues

1. The progress notes of the medical director, Dr. [redacted] M., lacked examination findings on monthly visits, and many physical findings on the annual history and physicals.

2. Some MDS forms reviewed have not been updated as required; [redacted] R., [redacted] B., and [redacted] B.

3. The medication administration records lack signatures for the nurses' initials. These should be done as soon as the first medication is given.

4. The nurses' notes lack complete descriptions of injuries and pressure sores including full location, complete measurements, and proper descriptions of drainage color, consistency, amount, and description of an odor.

5. Two residents were not properly covered while being wheeled back to their rooms from the shower room.

6. Most of the residents' care plans reviewed were incomplete and needed updating.

7. Residents were lined up in wheelchairs in the activity room, many sleeping, with no visual or auditory stimulation.

Environmental

8. The tile at the front entrance is cracked and broken.

9. The front exit sign was being blocked by the facility Christmas tree.

10. The floor of the front lounge has “settled” and is a potential hazard to residents walking or using ambulation assistive devices.

11. Two wheelchairs had torn armrests which could tear fragile skin.

12. The air-conditioning unit in the back hallway is falling away from the wall.

13. There were broken tiles in the shower room across from room 125.

14. There were feces on a shower curtain in the shower room across from room 125.

15. There was heavy equipment and chemicals in an unlocked storage closet at the rear of the shower room.

16. The floor in room 128 is damaged.

17. The counter on station three is damaged.

18. There was a large crack in the ceiling by station three.

19. There was a serious water leak from room 220 to the outside of the building.

20. There was trash strewn around the outside of the facility.

21. The garden hose was not properly stored outside.

22. Some light fixture covers on the outside of the building were missing.

23. There was a serious leak in the water hose to the washing machine in the laundry room.

24. There was a build up of lint behind the dryer in the laundry room.

25. There was a loose handrail by room 112.

26. The fire extinguisher by door one needs recharging.

27. There were some light bulbs burned out in the exit signs.

28. Multiple hand cranks on the beds were not properly stored.

29. There were used razors in a bucket beside a full sharps container under the sink in the utility room by station four.

30. There was linen stored within 18 inches of the sprinkler head in the linen closet.

31. There was food being stored with medications in the station three medication refrigerator.

32. There were flies noted in the kitchen.

33. There was undated food in the walk-in refrigerator.

34. Salads and desserts in the walk-in refrigerator were not properly covered.

35. Hamburger buns in the pantry were not properly stored after being opened.

36. The kitchen floor was dirty and there was meat on the floor by the stove.

Administrative

37. There was no documentation of reference checks or criminal background checks in the personnel files.

38. Residents complained about food being served cold when it was supposed to be hot.

39. Residents complained about being rushed through dinner on Tuesday nights for Bingo (has already been addressed by the administration).

Staffing

Staffing levels for the four days reviewed were all below the 3.2 hours required, and well below 3.0 on weekends.

Fire

a. There must be no impediment to closing doors. The following doors did not latch: 109, 112, 115, 120-121,123-124, 128, 320, 403, and business office.

b. The smoke barriers located at nurses' station #1 and #2 have penetrations. Penetrations must be sealed to maintain their fire resistance.

c. The smoke barrier door at nurses' station #3 did not release when the fire alarm was activated.

d. The emergency lighting did not respond within ten seconds. Lighting was provided after 34 seconds and an additional 30 seconds before there was a complete conversion of emergency power.

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INSPECTION REPORT SUMMAR #128

Andrea Campbell, Administrator
Care Center of Rossmoor
1224 Rossmoor Parkway
Walnut Creek, California 94595

Number of beds: 180

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Care Center of Rossmoor, located in Walnut Creek, on December 4, 2002. The team identified the following issues:

Care Issues

1. Dr. [redacted] M.'s history and physical examinations lack documentation of physical findings.

2. Dr. S.'s history and physical examinations lack sufficient documentation of physical findings. "No change" is insufficient. There also is no indication in his progress notes that he actually saw the residents.

3. The medication administration records lack signatures for the nurses' initials. These should be done as soon as the first medication is given.

Environmental

4. Several geri-chairs were found to have torn arms and backs.

5. There was popcorn left in the large popcorn popper in the dining room.

6. The exit door by room 104 was braced open with a rock.

7. There was a tangled hose in the dishwashing area of the kitchen.

8. There was a large hole in the wall of the dirty linen area of the laundry room.

9. There was heavy equipment being stored in the unlocked personal laundry room.

10. The janitor's room was unlocked, contained chemicals, and had a water leak.

11. There was a substance which appeared to be feces on the clean linen cart in the hallway.

12. The sliding door and screen in the rose room does not slide smoothly.

13. There were multiple torn and off-track windows and sliding door screens.

14. The door to the general storage room was found to be unlocked.

15. There was a plastic bucket containing an unknown substance labeled dangerous left outside the side door of the facility.

16. Oxygen tanks were not properly stored in an unlocked closet outside the facility.

17. The station two medication room was found to be unlocked and unattended.

Administrative

18. Residents' personal property lists were missing or incomplete in all samples checked.

19. Residents' personal property was not properly labeled.

20. Approximately half of the personnel files reviewed lacked documentation of a reference check.

Staffing

No problems were detected

Fire

a. Five year certification for sprinkler system needs to be completed.

care center
· of rossmoor ·

January 14, 2003

Larry Menard
Special Agent Supervisor
Bureau of Medi-Cal Fraud and Elder Abuse
2025 Gateway Place Suite 474
San Jose, CA 95110-1006

RE: Operation Guardian Inspection Report Response

Dear Mr. Menard:

This letter is to confirm receipt of the Operation Guardian Inspection report for Care Center of Rossmoor. The following actions have been implemented.

- A discussion of MD documentation requirements with our attending physicians occurred at our monthly Continuous Quality Improvement Committee Meeting.
- The licensed nurses received an education class on documentation requirements. Medical records department is auditing records for compliance.
- Equipment mentioned in the report has been cleaned, repaired, or replaced.
- The maintenance department has repaired the sliding doors, screens, and laundry room wall. The oxygen has been chained.
- The housekeeping staff and nursing staff received education regarding the locking of doors, and safety awareness for the residents and staff.
- Families and residents are informed upon admission of the facility "Theft and Loss Program" which includes the importance of completing an inventory and marking of personal items. The social services department is available to assist families with this process. The Social services department shall in-service the staff on the importance of personal inventory sheets and labeling of resident's property.
- Reference checks are required as part of the new hire process and newly hired employees are screened through reference checks. The Human Resources Director shall monitor.
- The Operation Guardian report was presented to the Continuous Quality Improvement Committee for future monitoring of the issues listed.

If I can be of further assistance please contact me at (925) 937-7450.

Andrea Campbell
Administrator
Care Center of Rossmoor

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INSPECTION REPORT SUMMARY #129

Daizel Gasperian, Administrator
Evergreen La Jolla Healthcare Center
2552 Torrey Pines Road
La Jolla, California 92037

Number of beds: 161

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Evergreen La Jolla Healthcare Center, located in La Jolla, on December 10, 2002. The team identified the following issues:

Care Issues

1. Staff was slow to answer call lights, especially in the morning.

2. The medication administration records and treatment administration records lack signatures for the nurses' initials. These should be done the first time the medication is given by each nurse.

3. Assessments and Minimum Data Sheets are not always up to date or completed in the time imposed by regulation.

4. Two residents complained that new staff is not responsive to the needs of the individuals and don't verbally respond to the residents.

5. Annual history and physical exams for the residents are not up to date in all records.

6. Dr. T. has not documented a progress note for his residents on a monthly basis. Many months are missing.

7. Dr. S. has not documented a progress note for his residents on a monthly basis.

Environmental

8. The housekeepers/janitors' closet was found unlocked and contained chemicals.

9. The second housekeeping closet was found locked, but with paper stuffed into the locking mechanism to keep the door open.

10. There were excessive rabbit feces on the patio walkways.

11. There was a large hazardous rabbit hole near the patio walkway, which needs to be filled in.

12. There were multiple torn and off-track patio and window screens.

13. Hallway handrails were very rough and need refinishing.

14. The shower room door by room 24 does not close properly.

15. The siderail to the bed in 28A was broken and partially lying on the floor.

16. The patio table on the patio is badly broken and a hazard to residents.

17. Bed hand-cranks were not properly stowed under the beds.

18. The drawers in residents' rooms were not properly closed and present a danger to anyone walking near them.

19. There was a lack of weatherstripping on exterior doors, allowing both cold air and flies into the facility.

20. There was a plastic bag left on the floor near the foot of the bed in room 20A.

21. There was a used razor on a shelf and a used glove on the floor of the shower room by room 24.The screen door in the kitchen does not latch properly.

22. There were improperly closed food containers in the kitchen pantry.

23. There was uncovered food in the kitchen refrigerator and undated food in the freezer.

24. The stucco along the covered parking at the side of the building is badly damaged in numerous places.

25. The door to the medication and medical supply room by the diningroom on station two was found to be unlocked.

26. The facility has the video on mandatory reporting, and the staff appears to have seen the video, but the documentation of the viewing was not available.

27. There were suppositories being stored in the refrigerator designated for lab specimens only.

Administrative

28. There was a lack of documentation of criminal background checks being run on care staff.

29. Residents' personal property inventory sheets were nonexistent.

30. Residents' personal property was not properly labeled.

Staffing

No problems were detected

Fire

Unavailable

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INSPECTION REPORT SUMMARY #130

Gerald Hunter, Administrator
Gilroy Healthcare and Rehab Center
8170 Murray Avenue
Gilroy, California 95020

Number of beds: 134

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Gilroy Healthcare and Rehabilitation Center, in Gilroy, on December 17, 2002. The team identified the following issues:

Care Issues

1. Upon entering the facility the team noted a moderate odor of urine throughout the facility indicating that they did not change residents in a timely basis during the night, or staff is failing to properly cover soiled linen cans.

2. During the inspection procedure we timed several call lights for staff response. They noted that during the first three hours of our inspection, staff took more than ten minutes to answer call lights. Many staff were observed walking past rooms with call lights on without checking on the needs of the resident.

3. The medication administration records lack signatures for the nurses' initials. These should be done when they give the first medication. Most often, the sheets also lacked results of PRN medication administration.

4. The nurses' notes lacked proper complete descriptions for injuries, and pressure sores including full location, complete measurements, and proper color descriptions. They are lacked detailed descriptions of drainage, color, consistency, amount, and description of odor.

5. The admission order for resident [redacted] K. (02-56-01) was not signed. For this resident the care plan calls for "oral insulin ." Since this does not exist the plan needs to be changed to an oral hypoglycemic agent.

6. Resident [redacted] B. (02-56-02) received no annual history and physical for the year 2000, as required. Nurses notes were nonexistent for long periods; 11/28/02-12/12/02, 10/17/02-1/31/02-11/11/02.

7. Resident [redacted] P. (02-56-03) has an initial history and physical in the medical record. However, it failed to address the G.I. bleeding for which, they had hospitalized the resident.

8. Resident [redacted] S. (02-56-04) has not had an annual history and physical documented since 10/9/00. Dr. Green, the primary physician, is not making the required monthly visits.

9. Resident [redacted] B. (02-56-07) has not had physicians' orders signed for the months of 10/02 or 11/02. The physician's orders are very short and difficult to read.

Environmental

10. There was considerable water leaking from the ceiling ducts from the rain. This created several puddles of water on the floor in resident areas.

11. There were excessive potholes in the back patio area, which could be a hazard to residents walking in that area.

12. There was a garden hose across the pathway of the patio that was not stored properly, creating a potential hazard to ambulating residents.

13. There were several flies observed in the residents' rooms and hallways.

14. There were numerous items on both sides of the hallway obstructing clear passage through them.

15. There was water damage noted to the roof of the facility.

16. Several floor boards of the facility were water damaged.

17. There were dirty gloves found on the floor in room 49.

18. Hallway Christmas ornaments were hung so low in some areas that they hit anyone passing by them.

19. The handrail next to room 60 was damaged exposing a nail, which could be hazardous to residents.

20. There were ants noted in the hallway and in some resident rooms.
21. There were dirty linens on the floor and mildew in the corners of the shower rooms. There were also missing and cracked tiles noted.

22. There was heavy equipment left outside in areas easily accessible to residents.

23. There was a broken electrical outlet cover in room 51.

24. There were several bent, torn and off-track window and sliding door screens noted, which could be the source of the flies in the facility.

25. The staff break room was consistently left open, and contained items that could be hazardous to the residents who may be confused.

26. There were snack/soda vending machines noted in unsupervised areas of the facility allowing confused residents on special diets unsupervised access.

Administrative

27. The residents' personal property inventory records were not up to date.

28. There was no record of the mandatory elder abuse reporting training in either the in-service documents or the individual personnel files.

29. The personnel file of CNA [redacted] H. had a positive PPD, but lacked both a follow up test and a chest x-ray in the file.

Staffing

Below minimum daily requirements.

Fire

a. Relocate the pressure relief valve for inspection test. Log monthly pressure test.

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INSPECTION REPORT SUMMARY #131

Judith Morales, Administrator
Greenhills Manor
238 Virginia Avenue
Campbell, California 95008

Number of beds: 45

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Greenhills Manor, in Campbell, on December 18, 2002. The team identified the following issues:

Care Issues

1. Upon entering the facility the team noted a slight odor of urine throughout the facility's hallways, which disappeared shortly after entry.

2. Dr. W. does not cosign progress notes made by his nurse practitioner, suggesting that he is not reviewing the notes and guiding the care.

3. Residents are not all being given an annual history and physical.

4. The nurses' notes for resident [redacted] M. (02-57-03) for a period after 12/7/02 have several blank lines, contrary to acceptable nursing practice.

Environmental

5. The hallway handrails are in need of sanding and refinishing as they are rough and could damage the fragile skin of the elder residents.

6. There were three slightly bent window screens.

7. There was permanent solution left out in an unlocked beauty shop.

8. There was an open bag of bread in the kitchen refrigerator.

9. There was a leaking faucet in the kitchen.

10. There was food being stored in the kitchen's janitor closet with chemicals.

11. There was a large gap in the screen door in the kitchen, which could allow flies into the kitchen.

12. The sugar container in the pantry was not closed properly.

13. There was wall damage in the diningroom.

14. There were mildew and a broken tile in the shower room.

15. There was blood noted on the door frame of the shower room.

16. There was an extension cord being used in room 12 for the television.

17. There was feces noted on the floor of a shower room floor.

18. There was substantial fence damage noted following the severe rain storms that have occurred during the past few days.

19. There were nearly empty laundry detergent containers left outside in an unsecured area.

Administrative

20. CNA [redacted] C. has a documented positive reaction recently to the PPD test, with no follow up testing and no chest x-ray ordered.

21. The LVN license of [redacted] G. expired on 11/30/02 and no update is in the personnel file.

22. The RN license of [redacted] S. expired on 7/31/02 and no update is in the personnel file.

23. There was a lack of documentation of reference checks in the personnel files.

Staffing

Below minimum daily requirements.

Fire

No problems were detected

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INSPECTION REPORT SUMMARY #132

Dave Yarbrough, Administrator
Sunbridge Care & Rehab
2353 23rd Street
Eureka, California 95501

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Sunbridge Care and Rehab, in Eureka, on January 8, 2003. The team identified the following issues:

Care Issues

1. All of the care plans reviewed were incomplete and did not adequately address the issues of the particular patient.

2. There was a general lack of up to date annual history and physicals on the residents.

3. Multiple residents had a slow, but steady weight loss that they did not address in the care plans or assessments. The notes written by the nutritionist did not match what they were writing in the nurses' notes, and did not address the problem.

4. The nurse's notes overall were lacking in complete descriptions of injuries, pressures sores, and other wounds and problems. There was a lack of documented follow up and assessment.

5. There was a substantial lack of nurses' signatures for their initials on the medication administration records.

6. Physicians' orders are not always properly noted with the licensed nurses' signature, the date, and time of noting.

7. Dr. M. is not making monthly visits to the residents in his care. Dr. M. is not signing physicians' orders as approved by him for up to three months at a time.

8. Dr. G. is not making monthly visits.

9. Dr. O. is not making monthly visits.

10. The physicians' orders dated 11/7/02 and 1/7/03 are not noted by licensed staff.

11. Resident [redacted] H. (02-58-02) had a weight loss of 7 pounds from 12/9/02 and 12/25/02, which they did not address in the care plan.

12. Resident [redacted] S. (02-58-03) was to have her iron level and albumin checked. They did not document this in the file. It was also care planned for the dietician to assess the resident for protein/calorie need. They did not document this as done.

13. Resident [redacted] M (02-58-05) lacks an initial history and physical in her medical record.

14. Resident [redacted] L. (02-58-07) lacks an initial history and physical in her medical record.

Environmental

15. There was a moderate odor of urine noted when the team entered the facility at 7:00 a.m.

16. The hallway handrails are in need of sanding and refinishing to prevent skin injuries to the residents.

17. The medical records room, which contained multiple patient files, was unlocked and unattended.

18. There was food in the kitchen refrigerator that they did not properly label.

19. There was bread in the kitchen that had been left open and undated.

20. The floor behind the kitchen stove and the sides of the counters was exceptionally dirty.

21. There were snack and soda vending machines on the patio in an unsupervised area, which creates a potential problem for confused residents on special diets.

22. The wooden tables on the patio were very rough and covered with algae.

23. There was damage to stucco in several places on the exterior of the facility.

24. There were windows open with no screens on them, allowing flies and other insects access into the facility.

25. There were torn and bent screens on multiple windows.

26. There were three dead roaches found in the shower rooms.

27. The walkway on the south side of the facility was uneven, making walking hazardous for unsteady residents.

28. There was moss growing on the roof of the facility on the north and east sides of the facility.

29. There was roof damage noted on the east and west sides of the facility.

30. There was ceiling damage noted in the lobby.

Administrative

31. The personnel file of CNA [redacted] B. lacked documentation of a certificate number and expiration date, although there is a note that she passed the exam in June 2002. There are multiple reprimands for this CNA without adequate follow up.

32. The personnel file of LVN [redacted] N. has no documentation of an annual physical since 2000.

33. There is no TB testing or a physical exam documented in the personnel file of dietary supervisor R J.

34. The personnel file of LVN [redacted] J. has no California license in it. There is also no physical exam on file.

35. There is no TB testing or physical exam in the personnel file of CNA [redacted] T.

36. There was no certificate on file for CNA [redacted] M.

37. There is no up to date certificate on file for CNA [redacted] F., and no results documented on his TB testing.

38. There is no TB testing or physical exam in the file of RN [redacted] S. There were also reprimands for abuse in her file.

Staffing

Staffing levels were well below the required levels on all days reviewed.

Fire

a. Log smoke detector and/or fire pull station location on monthly drill forms.

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INSPECTION REPORT SUMMARY #133

Robert Stauff, Administrator
St. Luke Manor
2321 Newburg Road
Fortuna, California 95540

Number of beds: 104

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Gardians team conducted a surprise inspection of St. Luke Manor in Fortuna, on January 9, 2003. The team identified the following issues:

Care Issues

1. Some annual history and physicals from the last two years were not in the medical records. They should be in the file to be available for emergency use.

2. The physicians' progress notes written by Dr. B. were very short and lack any physical findings that would indicate he had done a physical exam on the resident during each visit.

3. The record of resident [redacted] L (02-59-02) lacks an annual history and physical for 2002, and lacks a rehab potential documented by the physician. The physician's progress notes are missing for 6/02, 10/02 and 11/02, suggesting that the doctor is not making monthly visits. His note is also lacking physical findings necessary to bill for a visit.

4. The record of resident [redacted] E. (02-59-03) lacked an annual history and physical for 2002. There were no physicians' progress notes by Dr. R[redacted] for 1/02, 2/02, 3/02, 4/02, 6/02, 8/02, and 11/02. This suggests that he is not making the monthly visits for this resident.

5. The record of resident [redacted] P. (02-59-05) is lacking an annual history and physical for 2002 (the last one is dated 5/4/01), and the physician's progress notes lack any physical findings that would show that a physical exam is being done when the physician makes the monthly visit.

6. Overall most of the physicians having residents in the facility are failing to make monthly visits.

7. Overall the physicians' progress notes lack documentation of physical findings to show that the doctor made contact with the resident.

8. The residents' records lack annual history and physicals done regularly, and lack a necessary interim history.

9. There was a substantial lack of documentation of the results of PRN medications that they had given.

10. MDS forms were not completed in a timely manner on some records reviewed.

11. Care plans, overall, were lacking in goals and time periods, as well as continued assessment.

Environmental

12. There was a noticeable odor of urine in the hallways when the team entered the facility.

13. There were several lights burned out in the exit signs.

14. There was an oil leak in the emergency generator.

15. There was a soiled glove on the floor and a leaking faucet in the station 2 utility room.

16. The fire extinguisher by room 47 needs recharging.

17. There was an extension cord being used to connect the television in room 42.

18. There was clothing and coat hangers on the floor of the station two storage closet.

19. There was soiled linen left in the station two shower room.

20. Many water pitchers in the residents' rooms were dirty, and out of reach of the residents.

21. There was a bent screen in the laundry room that can allow flies entry into the facility.

22. There were snack and soda vending machines, and a candy dispenser at the entrance in an unsupervised area of the facility. This creates a potential hazard for residents on special diets.

23. There was floor damage from an obvious leak along the wall/floor line in the medication room.

24. There was trash left on the floor of the shower room across from room 21.

25. There is a missing baseboard in room 23.

26. The station #1 utility room had soiled linens stored improperly causing a strong odor.

27. There was an obvious leak at the base of the hopper in the utility room.

28. The faucet in the station 1 utility room is leaking.

29. There were heavy equipment and chemicals being stored in an unlocked and unattended storage room.

30. The back hallways were cluttered on both sides blocking clear passage.

31. They are storing oxygen tanks in a room with a large unused incinerator that was still filled with very fine ashes. These ashes could easily clog the connections on the tanks.

32. There were used razors left on a shelf in the shower room.

Administrative

33. Your facility did not post the Department of Health Services annual survey in a prominent and easily visible area.

34. The personnel file for CNAs [redacted] H., [redacted] B., and [redacted] B. lacked a current certification and expiration date, documentation of a reference check and elder abuse training.

35. The records of several CNA's indicated that they had been changed from CNA's to "transportation." They were still being counted as patient care staff.

36. During a resident interview, we discovered a property theft reported to the nursing staff and never followed up by the administrative staff, or reported to the Ombudsman or law enforcement.

Staffing

Below minimum daily requirements.

Fire

a. Interior exit door sign light burned out.

b. Auxiliary generator leaking oil.

c. No fire extinguisher in storage shed.

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INSPECTION REPORT SUMMARY #134

Kathy Campbell, Administrator
Earlwood Care Center
20820 Earl Street
Torrance, CA 90503

Number of beds: 87

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Earlwood Care Center, located in Torrance, on January 15, 2003. The team identified the following issues:

Care Issues

1. Dr. [redacted]. S.'s physician's orders are not signed on a regular basis. Further, he is failing to visit residents on a monthly basis.

2. Nursing notes are incomplete.

Environmental

3. There were screens missing from two windows, allowing insects to enter the building when the windows were open.

4. An open, undated bag of powdered milk was found in the pantry.

5. The refrigerator contained uncovered and undated food. Some of the items had mold on them and were unidentifiable.

6. The freezer contained an open, undated package of corn.

7. There was eve support damage on the east side of the building.
8. Shower room number four had mildew on the tile.

9. The rear janitor's closet door was found unlocked and contained a bottle of spray cleaner. This presents a potential hazard to residents who could gain access to this material.

10. There was uneven floor tile in the south hallway, creating a hazard for ambulating residents.

11. There were two holes in the floor of the dining room, again creating a potentially hazardous environment for ambulating residents.

Administrative

12. Licensing or certification certificates were expired or missing from the staff personnel files reviewed.

13. The personnel files also did not contain complete records documenting employees medical examination for employment. The criminal background checks were also not located.

14. There were no termination records in any of the terminated employee's files.

Staffing

We reviewed staffing levels on eleven randomly selected days from November 2002 to January, 2003. Of those days reviewed, not one day showed that the minimum required 3.2 hours per patient day was met. Only four days reached 3.0 hours.

Fire

No problems were detected.

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INSPECTION REPORT SUMMARY #135

Rosie Velasco, Administrator
Marina Care Center
5240 Sepulveda Boulevard
Culver City, CA 90230

Number of beds: 116

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On January 16, 2003, the Operation Guardians team conducted a surprise inspection of Marina Care Center, in Culver City. The team identified the following issues:

Care Issues

1. Our team physician noted that several residents appear to be overly medicated.

2. The nurses' notes were inadequate, and we noted several charts in which periods of up to six months were charted on less than one page.

3. MDS entries lacked sufficiency.

4. While walking through the building, we observed a patient in room number 49, laying in his bed, wearing only a diaper. A female staff member was in the room feeding another patient, making no attempt to provide privacy for the partially clad resident.

Environmental

5. There was an open, unlocked, and unattended medicine cart in the hallway.

6. A janitor's closet was unlocked and contained chemicals and cleaning supplies.

7. There was matted hair on a shower chair, and dirty, wet linen on the floor of shower room number three.

8. The whirlpool room contained personal belongings, food, and janitorial equipment.

9. Rotten vegetables and open, undated meat packages were found in the refrigerator.

10. There is a rotten rain gutter on the south side of the building.

Administrative

11. Except for the licenses and certificates of employees kept in a separate folder, the employee files were very unorganized.

12. Personnel records did not show that employees were receiving complete TB tests.

13. Background checks of employees were not consistently completed.

14. The documentation for Elder Abuse training was lacking.

Staffing

The team reviewed several random days for staffing levels. Not one of the days staffing reviewed showed the minimum required 3.2 hours per patient day.

Fire

a. Fire extinguisher in kitchen needs immediate servicing.

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INSPECTION REPORT SUMMARY #136

Anthony Thekkek, Administrator
Bay Point Healthcare Center
442 Sunset Blvd.
Hayward, California 94541

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Bay Point Healthcare Center in Hayward, on January 22, 2003. The team identified the following issues:

Care Issues

1. Most of the annual history and physicals reviewed lacked a documented interim history.

2. Many annual physicals reviewed lacked adequate physical findings documented.

3. We reviewed physicians' order sheets and it was found that the nurses consistently failed to document the time that orders were noted.

4. There was a consistent lack of signatures for the initials on the treatment and medication administration records.

5. There was a substantial lack of documentation of the results of PRN medications that they had given.

6. MDS forms were not completed in a timely manner on some records reviewed.

7. Care plans for residents with frequent falls were lacking in goals and time periods, as well as continued assessment.

8. Resident [redacted] T. (02-62-06) had a doctor's order for Diabeta that they transcribed as Dilantin. They transcribed the improper order incorrectly several times.

9. Resident [redacted] T. (02-62-07) had an order written for a follow up chest x-ray written on 1/16/03 that they did not document as noted.

10. Resident [redacted] H. (02-62-08) lacks an adequate care plan and the Minimum Data Set is still blank.

Environmental

11. There was a noticeable odor of urine in the hallways when the team entered the facility.

12. There were substantial amounts of slippery slime and moss under the gutter downspouts.

13. The handrails in the hallways were dirty and rough, and are in need of sanding and refinishing to prevent skin tears on fragile elders.

14. There was a leaking faucet in the Station one utility room.

15. The door to the staff lounge was propped open and the lounge contained soda and snack machines, and a microwave oven.

16. There was undated food in the kitchen refrigerator.

17. There were food containers in the kitchen pantry that had not been properly closed.

18. The exterior screen door in the kitchen does not close properly and the staff keep the door open due to the heat in the kitchen.

19. Staff are not properly using the occupancy signs on the shower room doors.

20. There is maintenance equipment being stored in the shower room that could be hazardous to residents wandering into the room.

21. Many residents' door frames were not properly secured to the entryway walls.

22. There were extension cords being used in room #6 and #7.

23. There is a large crack in the flooring in room 15.

24. Clean linens are being stacked too high (above the red line) in the clean linen closets.

25. Empty oxygen tanks were not being secured properly.

26. Bed cranks were not properly stored under the beds in residents' rooms, creating a hazard to anyone walking near the beds.

27. The treatment cart on station #2 was unlocked and unattended.

28. There were some bent screens on resident windows, and a sliding door screen that was completely off-track.

29. There was an abundance of rotting fruit on the ground from the fruit trees outside the facility that could cause a slipping hazard.

30. There were several large containers of cleaning chemicals left outside the facility in an unsecured area.

31. There was an old water heater lying on the ground in a grassy area at the back of the facility which needs to be hauled away.

Administrative

32. Physical exams and/or TB testing were missing in the following personnel files; [redacted] J. RN, [redacted] I. LVN, and A[redacted] (name unreadable) CNA.

33. Residents' personal property inventory records were not up to date and they did not mark some personal property.

Staffing

Below minimum daily requirements.

Fire

Unavailable.

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INSPECTION REPORT SUMMARY #137

Claude Linkous, Administrator
Eden West Convalescent Hospital
1805 West Street
Hayward, California 94545

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Eden West Convalescent Hospital, in Hayward, on January 23, 2003. The team identified the following issues:

Care Issues

1. Residents complained repeatedly about staff failing to answer call lights in a timely manner, taking an average of 30 minutes and up to an hour.

2. Based on the review of the medical record by the team's nurse and medical consultant, the notes show that the resident ([redacted] W. 02-63-02) is in need of more fluids. The water pitcher by her bed was out of reach.

3. The physicians' orders dated 1/16/03 for resident [redacted] W. lacked documentation of noting by the nurse.

4. The physical exam in the record of [redacted] H. (02-63-04) has a good history, but no physical findings.

5. The history and physical in the record of [redacted] N. (02-63-07) is incomplete with just a few lines filled in on the form.

6. The nurses' notes on resident [redacted] N. are very scant, and lack detail.

7. Resident [redacted] B. (02-63-08) needs follow up lab work, and the care plan needs to

be individualized for this resident.

8. Resident [redacted] B. (02-63-09) was complaining of abdominal pain, had very strong smelling urine, a lack of water within reach, and a history of urinary tract infections. Follow up is needed by the physician and better hydration by the staff.

9. Resident interviews indicated that resident [redacted] C. (02-63-10) fell recently. The staff failed to answer the call light until another resident physically summoned someone. The nurses' notes failed to document the incident until days later when they noted bruising and they ordered an x-ray. There was also no notification to the Ombudsman, family, or physician at the time of the incident.

10. In general, nurses' notes lacked details, particularly regarding falls and injury descriptions.

11. Many treatment and medication administration records lack nurses' signatures for their initials.

12. In general, the annual history and physicals lacked an interim history and complete physical findings.

13. The nurses are failing to document the time when they note physicians' orders.

Environmental

14. The faucet in shower room one is leaking.

15. There was a mild to moderate odor of urine when the team entered the facility.

16. The patio screens do not slide properly and are too difficult for residents to slide.

17. The lock and keys for shower room doors were not working properly.

18. The hydroculator in the therapy room was extremely hot, but the door to the room was open and no one was in attendance. This is a potential hazard to wandering curious residents.

19. Bed cranks were not properly stowed under the beds and create a potential hazard to anyone passing near the foot of the bed.

20. There was a used glove found on the floor of shower room three.

21. There were three wheelchairs/geri-chairs noted which had torn armrests.

22. On the residents' patio, the team noted slime growing under the gutter down-spouts creating a slipping hazard. An extension cord was hung from a tree. There was an improperly stored garden hose across the walkway path, and sand bags propped against sliding doors.

23. There was a large piece of wiring and several large rocks covering a drain hole. This needs a proper cover.

24. The door knob to the whirlpool room is extremely loose.

25. Oxygen tanks were not properly secured in the oxygen closet.

26. The housekeeping storage room near room 50 was found unlocked and unattended, and contained cleaning chemicals.

27. There was wall damage under the dishwashing sink in the kitchen.

28. The janitor's closet was found unlocked and unattended, and contained multiple chemicals.

29. The exterior door in the laundry room was wide open with no screen, due to the heat in the room.

30. There was a soiled glove found on the patio.

31. The staff lounge door was open and unattended. The staff lounge contains both snack and soda machines that allow residents unsupervised access to the machines, which could be a potential hazard for residents with dietary restrictions.

32. Residents complained that the rooms are too cold at night.

Administrative

33. Residents complained that the lunch served frequently does not match the posted menu. They frequently get sandwiches that are sometimes very "soggy."

34. Residents' personal property inventory records were not up to date and they did not mark some personal property of the residents.

35. Several personnel files reviewed lack a name and date on the physical examination form.

36. The personnel file of [redacted] H. lacked the results of TB testing, [redacted] C. lacked a physical examination, and [redacted] R[redacted] had no physical exam or TB testing on file.

37. There was no current license in the file of RN [redacted] B., LVN [redacted] D. has no license copy on file, and CNA [redacted] S. has no certification copy on file.

Staffing

Below minimum daily requirements.

Fire

a. City of Hayward business license expired 7/02. Renewal required.

b. Light bulb in shower room # 3 burned out.

c. Repair the door in the admissions coordinator's office.

d. Bell or sounding device to be heard when water flow tested.

e. Beds in way of closing door.

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INSPECTION REPORT SUMMARY #138

Jean Jardine, Administrator
Mt. Pleasant Nursing Center
1355 Clayton Road
San Jose, California 95127

Number of beds: 54

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On February 4, 2003, the Operation Guardians team conducted a surprise inspection of Mt. Pleasant Nursing Center, at 1355 Clayton Road, in San Jose, The team identified the following issues:

Care Issues

1. There was a moderate odor of urine noted when the team entered the facility.

2. The history and physicals done by Dr. W. lack interim history and physical findings, and are inadequate for Medi-Cal billing.

3. The nurses' notes lacked details of bruising, such as exact sizing and color with a more exact location. This was also evident for other injuries noted.

4. The medication administration records lacked signatures for all nurses initials who pass medications.

5. There was a lack of ongoing assessments on residents problems.

6. Care plans did not clearly state the goals and objectives and did not always match the current status of the resident.

7. The nurses are failing to document the time when they note physicians' orders.

8. The weekly nursing assessments frequently lacked a date, sometimes lacked a nurse's signature, and always lacked the time that they wrote it. All shifts should do assessments not just by one person on the day shift.

9. Blood pressures were being rounded off (130/70 was the most frequently used), suggesting faulty blood pressure cuffs or improper technique.

10. The resident in 104A sleeps all day and talks loudly all night, keeping the other resident awake. The sleep pattern of the resident in 104A needs to be addressed and care planned.

11. There were opened cans of nourishments in the medication refrigerator.

Environmental

12. The eye wash station was found unlocked and unattended, and contained chemical substances that could be a hazard to confused residents.

13. There was a used glove found on the floor in room 108.

14. The beauty shop/activity supply room was found unlocked and unattended, and contained several hair treating chemicals that could be hazardous to confused residents.

15. There were sodas and candy vending machines in the hallway allowing unsupervised access by confused residents who are on specialized diets.

16. The door to the employee lounge was found open. It contained staff's personal property, and a microwave, which could be hazardous to confused residents.

17. There was a large deposit of mildew beginning to grow in the shower room.

Administrative

18. The Department of Health Services survey report was found at the nurses station under a stack of phone books, in an unmarked blue binder. It is to be displayed in a prominent place easily accessible by the public.

19. Personnel files generally lacked documentation of reference checks.

20. The personnel file of LVN [redacted]A. lacked an up to date license.

21. The personnel files of CNA [redacted] D. lacked a valid certification in the file.

22. The personnel files of CNA's [redacted] D. and [redacted]K. lacked both a physical exam and TB testing results.

Staffing

The staffing levels were below the minimum required for three of the four days reviewed by the team.

Fire

Unavailable

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INSPECTION REPORT SUMMARY #139

Charles Bruffey, Administrator
Pacific Hills Manor
370 Noble Court
Morgan Hill, California 95037

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On February 5, 2003, the Operation Guardians team conducted a surprise inspection of Pacific Hills Manor, in Morgan Hill. The team identified the following issues:

Care Issues

1. There was a mild to moderate odor of urine throughout the facility when the team entered.

2. The team noted that some staff are not properly and completely covering residents when they transport them back and forth from the shower.

3. The medical record of resident [redacted] E. (02-65-01) needs an updated Digoxin level, per the team medical consultant. There was also a lack of follow up lab work for a recent Urinary Tract Infection.

4. Dr. [redacted] J. was not making monthly visits to his patients.

5. The medication administration records and treatment records lack signatures for most of the nurses' initials. These should be done when the nurse gives the first medication.

6. The medication administration records lacked results of the PRN medications given, and "request" as the reason they gave the medication is inadequate. They must be more specific.

7. The nurses' notes lack proper complete descriptions for injuries, and pressure sores including full location, complete measurements, and proper color descriptions. They lack proper descriptions of drainage, color, consistency, amount, and description of odor.

8. The nurses' notes frequently lacked the time the note was written and there was not a weekly summary being written for each resident regularly.

9. The licensed staff did not note physicians' orders with the nurses' signature, and the date and time of noting.

10. Physicians' progress notes by Dr. [redacted] G., Dr. [redacted]. L., and Dr. [redacted] J. lacked physical findings showing an examination of the resident took place.

11. MDS assessments were not all done in a timely manner.

12. They did not update residents' care plans in a timely manner and did not match the status of all the residents reviewed.

13. The annual history and physical in the residents medical record is just a rubber stamp and shows no physical findings to show that a physical examination actually occurred.

Environmental

14. The bed cranks on most of the residents beds had been left out, rather than being properly stored under the bed. This is hazardous to anyone walking near the foot of the bed.

15. There was a ladder left on the patio that could be hazardous to confused residents in the area.

16. There were two fire extinguishers found by the team that were in need of recharging.

17. The hallway handrails were in need of sanding and refinishing.

18. There were several sliding screens that stick and do not slide properly. Many were also off-track.

19. There was a water leak behind the kitchen refrigerator.

20. There was wall damage in the kitchen in the dishwashing area, and in the food prep area.

21. Floor polishers were left unattended in the hallways and could present a danger to residents walking in the area who may be unsteady on their feet.

22. There was tile damage noted in the shower room by the laundry.

23. There was a used glove left in the shower room by the nurses' station.

24. The key to the utility room, containing the hazardous waste, had been left in the door lock that negates the purpose of having the door locked.

25. The staff room door was propped open. It contained snack vending machines, hot coffee makers, microwave and a refrigerator for the staff. It should be closed at all times.

Administrative

26. The residents' personal property inventory records were missing in many records and were not up to date in the ones found. They had not signed or date them also.

27. Several residents' personal items were lacking proper labeling.

28. The personnel file of CNA [redacted] M. lacked documentation of TB testing.

29. The personnel file of CNA [redacted] L. lacked a certification and expiration date.

30. The personnel file of CNA [redacted] G. lacked documentation of TB testing and a physical examination.

31. The personnel file of RB [redacted] D. lacked the physician's signature and date on the physical examination.

Staffing

Staffing levels were below the required 3.2 hours per patient day on three of the fours days reviewed. One was below 3.0.

Fire

Unavailable

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INSPECTION REPORT SUMMARY #140

Bonnie Vela, Administrator
Maywood Acres Healthcare
2641 South C Street
Oxnard, California 93033

Number of beds: 98

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Maywood Acres Healthcare, in Oxnard, on February 19, 2003. The team identified the following issues:

Care Issues

1. There was a moderate odor of urine throughout the facility when the team entered, which persisted in some areas during the inspection.

2. The medication administration records lacked signatures for the nurses' initials. These should be done when they give the first medication.

3. The nurses' notes lacked proper complete descriptions for injuries and pressure sores, including full location, complete measurements, and proper color descriptions. They lacked proper descriptions of drainage, color, consistency, amount, and description of odor.

4. Resident care plans did not fully reflect the needs of the resident.

5. The nurses noting the physicians' orders are failing to document the time that they noted the orders.

6. Nurses' weekly summaries are repetitive and lack details, and do not fully reflect the status of the resident for each shift on a rotating basis.

7. Approximately 30% of the medical records reviewed are in need of updated lab work.

8. Six of the nine medical records reviewed show residents prescribed more than 10 medications.

9. Resident [redacted] S. (02-66-04) has lost 24 pounds in three months and lacks an adequate nurse's evaluation for this problem.

10. Resident [redacted] B. (02-66-08) has not had her annual history and physical updated since 12/20/00.

11. Residents complained about meals not being served on a regular basis, and they arrive cold. The team confirmed this. Both breakfast and lunch were served at least 45 minutes later than the posted meal times and the tray carts sat in the hallway for prolonged periods without being served.

12. Residents complained about poor staffing, particularly at night. Staff reportedly is slow to answer call lights.

13. Residents complained that the facility is too cold at night.

14. The medication cart was found in the hallway near the nurses' station unlocked and unattended.

Environmental

15. Shower room occupancy signs are attached to the shower room doors, but they are not being used properly by the staff. Some are also broken.

16. The hallway handrails are in need of sanding and refinishing to prevent skin tears on the fragile skin of the residents.

17. We noted that most bed cranks are left out which can injure anyone walking near the end of the bed.

18. There was a candy dispenser observed near the facility entrance that allows unsupervised access by confused residents with both dietary and swallowing problems. This is a potential hazard that the administrator addressed before the team left.

19. Most closets, including the linen closets, had items stacked too close to the sprinkler heads violating fire codes.

20. Many residents' overbed tables are in need of repair.

21. Both sides of the hallways were cluttered with wheelchairs and carts which block clear access to emergency exits.

22. There were snack and soda vending machines noted on the residents' patio, an unsupervised area. This presents a potential hazard to residents with dietary restrictions and swallowing problems.

23. The staff lounge contains a microwave oven, a hot coffeepot, and a staff refrigerator. The door was open, allowing confused residents clear, unsupervised access to potential hazards.

24. There was a bent screen in the laundry room, which allows flies into the facility.

25. There was uncovered salad in the kitchen refrigerator that was wilted.

26. There were several moldy cantaloupes in the walk-in refrigerator in the kitchen.

27. There were multiple bent and off track screens noted on residents windows.

28. There was a wasp nest noted under the eaves in the front of the facility.

29. There was a large broken brick left on the patio that could cause a hazard to someone walking in that area.

30. There was stucco damage noted to the outside of the facility in multiple areas.

31. The wooden benches on the side of the facility are rotting and splitting, and are in need of repair or replacement.

Administrative

32. Personnel files reviewed lacked documentation of reference checks. Many physical exams also lacked a date. Certifications in the files were not always up to date:

1. CNA [redacted] E.- certification expired 5/30/02.

2. CNA [redacted] G.- certification expired 11/19/98.

3. RN [redacted] R. has no license in her file.

4. CNA [redacted] T. has no certification copy in her file with an expiration date.

Staffing

Staffing was randomly checked and found below required levels for the six days reviewed. Four of the six days were well below 3.0 hours per patient day.

Fire

a. North dining room alarmed exit egress blocked by landscape and vehicle

parking.

b. Medical Records office exit was blocked by file boxes.

c. Assure that patient beds and other equipment do not restrict corridors.

d. Smoke detectors must be installed in patient sleeping rooms. The power for these detectors shall come from the building wiring.

Maywood Acres Healthcare

A Kindred Community

April 16, 2003

BMFEA
State of California
Department of Justice
Diana Boutin, Special Agent Supervisor
2025 Gateway Place, Suite 300
San Jose, CA 95110

Dear Ms. Boutin,

This letter is in response to the inspection report I received re: the surprise inspection ~~of Maywood Acres~~ Healthcare on February 19, 2003. I will respond to the issues in the numbered order they appeared in the correspondence.

1. We have a full time housekeeping staff and the facility is cleaned on a daily basis. With many incontinent residents we do keep them changed clean and dry.
2. The licensed nurses have been educated to sign their initials at the time of the medication administration.
3. The nurses have been inserviced on the proper documentation for pressure sores.
4. Care plans are in the process of being updated to reflect needs of the resident.
5. Nurses have been educated to be sure to reflect the time that physician orders are noted.
6. Education is being given by the Director of Nurses on writing appropriate and informative weekly summaries.
7. Physicians are being contacted to request lab work.
8. The pharmacy consultant is reviewing medications on a monthly basis and addressing the issue of 9 or more medications.
9. Weekly weight meetings are held and weight loss is addressed with the dietician and the physician is informed for treatment. Nursing has been inserviced to reflect in the nurses notes the action taken. This particular resident has a current weight of 208# and was admitted with a weight of 205#.
10. Medical Records is to audit all records to assure all H&P's are done timely.
11. The Dietary Services Manager has trained the dietary staff to serve the meals on time and the nursing staff inserviced to pass the trays promptly.
12. All staff has been inserviced re: answering the call lights promptly.
13. We have plenty of blankets for use and extra blankets have been given to the residents.
14. Licensed nurses have been educated to keep the carts locked at all times when not attended.
15. New occupancy signs have been order and staff advised how to properly use them.
16. All handrails have been sanded and refinished and are done so on an ongoing basis.
17. Staff has been educated to put the cranks in the proper position.
18. The candy machine was moved to the employee lounge.
19. All items in the storage closets are below the required level.
20. Overbed tables are being replaced on a monthly basis.
21. Staff has been reminded to store wheelchairs and in proper storage area.
22. Both vending machines have been removed.
23. A self-closing door is being used for the staff lounge.
24. All screens have been replaced.
25. The salad was disposed of.
26. The cantaloupes were disposed of.
27. All window screens have been replaced.
28. The wasp nest was destroyed.

2641 South C Street Oxnard, California 93033

We appreciate your professionalism and your comments to help us be a better facility.

We appreciate your professionalism and your comments to help us be a better facility.

Bonnie Vela
Administrator

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855
Personal (916) 263-0809

INSPECTION REPORT SUMMARY #141

Larry Oshinsky, Administrator
Acacias Care Center
601 N. Mongomery Street
Ojai, California 93024

Number of beds: 50

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On February 20, 2003, the Operation Guardians team conducted a surprise inspection of Acacias Care Center, located in Ojai. During the inspection the team noted the following issues:

Care Issues

1. There was a moderate odor of urine throughout the facility when the team entered, which persisted in some areas during the inspection.

2. The team found expired drugs in the medication refrigerator at the nurses' station.

3. The medication administration records lack signatures for the nurses' initials. These should be done when they give the first medication.

4. The nurses' notes lacked proper complete descriptions for injuries and pressure sores, including full location, complete measurements, and proper color descriptions. They lacked proper descriptions of drainage, color, consistency, amount, and description of odor.

5. Resident care plans did not fully reflect the needs of the resident.

6. Time of writing was not present on the nurses' weekly summaries. It also appeared that the day shift wrote all summaries. They should rotate the weekly summary writing between both shifts to properly document the activities of the resident. Notes are also repetitive and lack any depth.

7. MDS forms are to be completed by multiple disciplines and people. Most of those reviewed had no signatures, a couple had one signature and one had two signatures. This is insufficient.

8. The interdisciplinary team conference forms reviewed lack any notes. A date and patient name are insufficient documentation.

9. Resident [redacted] B. (02-67-04) needs updated lab work done.

Environmental

10. Residents complained about the electrical system lights do not always work and the rooms are too dark.

11. The hallway handrails are in need of sanding and refinishing to prevent skin tears on the fragile skin of the residents.

12. Most bed cranks were noted to have been left out which can injure anyone walking near the end of the bed.

13. The light was burned out in the oxygen room, many storage closets, and many exit signs.

14. Ceiling tiles were missing in areas throughout the facility.

15. The door alarms to the exterior doors were turned off when the team arrived, and were still off at 8:30 a.m., defeating the purpose of having them.

16. The closet labeled “Oxygen Room” was empty. This could be a problem for registry personnel or new staff in an emergency.

17. There was a loose handrail by the resident dining room.

18. There was trash and old equipment near the building outside the facility. This could be hazardous to wandering residents, and creating an unsightly atmosphere.

19. The front door to the facility did not close properly. There was also a lack of good weatherstripping. Both problems allow flies into the facility.

20. There is a refrigerator in the hallway, in a small alcove. The refrigerator contains multiple food items that could be hazardous to confused residents. The refrigerator is in an unsupervised area allowing such access to all residents and visitors.

21. The wastebasket in the nurses’ station was overflowing with trash and the litter extended to the floor.

22. The closet floors in the hallway storage rooms were very dirty.

23. The oxygen tanks in the oxygen storage closet were not properly secured.

24. A table on the patio was severely damaged and could cause injury to residents.

25. There were two tricycles, an improperly stored garden hose, BBQ lighter fluid and an unsecured gas BBQ at the back of the facility by a semi-attached building. These items were easily accessible to the residents and is a potential hazard to wandering residents.

26. A low fence with no lock surrounded the above items.

27. Dirty linen containers were not properly closed, allowing foul odors into the hallways.

28. The drinking fountain in the hallway was corroded and not working.

29. The washing machine in the laundry room was not working. The second machine was out of order and had been that way for a prolonged period.

30. There was excessive lint built up in the back of the dryer, which could create a fire hazard.

31. There was a hole around the water meter that could be hazardous to residents wandering in the area.

32. There was excessive junk against the fence at the corner of Montgomery and Grand.

33. There were rotting olives on the ground under the tress on the Grand Ave. side of the building.

34. There were several bent and torn screens on the windows of the facility that would allow flies into the facilities when the windows are open.

35. There were multiple holes in the concrete that were formerly post holes, in the courtyard area, which would be hazardous to residents walking in the area.

36. There was an improperly stored garden hose left in the courtyard area that would be hazardous to anyone walking in the area.

Administrative

37. Personnel files reviewed showed several problems:

    a. CNA [redacted]B.- missing TB testing documentation; physical examination states it is needed.

    b. LVN [redacted] M. has no medical file available; no TB testing and no

physical exam documented.

c. CNA [redacted] A. has no medical records available; no TB testing and no physical exam documented. She also has not been signed off on any policy or skills.

d. CNA [redacted] C. has no TB testing documented.

e. LVN [redacted] K. has no update on her annual physical exam since 3/31/01.

f. LVN [redacted] J. has no current license on file (expired 2/28/01), no TB testing in file at all, and the last annual physical exam was completed on 5/14/01.

g. RN [redacted] P. had conflicting TB results. A chest x-ray result in the file dated 2/3/99 indicates that she has a history of positive PPD tests (therefore should not have had any further PPD tests). However, there is a recent PPD test in the file showing that the PPD is negative.

37. The residents' personal property inventory records were not up to date.

38. There were multiple fire code violations noted by the Fire Inspector, which they listed and left with the administrator by the inspector.

Staffing

Staffing for January 11, 2003 was questionable. It appears that the licensed staff person left at approximately 5:00 p.m. and the oncoming nurse did not arrive for about two hours. This left the facility with no licensed staff person for a two-hour period. Staffing for that day only amounted to 2.6 hours per patient day. This is also well below the required level. **The facility provided documentation by mail showing that there was coverage for that two hour period.**

Fire

a. Burned out exit sign at main entrance.

b. Two exit signs burned out beside rooms #1 & #2.

c. Burned out exit sign at beauty salon.

d. Removed stopper on front exit ramp.

e. Burned out exit sign in stairwell.

f. Adjust self-closer on downstairs stair door.

g. adjust self-closer on both kitchen doors.

h. Provide 30" minimum clearance around electrical panel in kitchen.
i. Burned out exit sign in corridor at kitchen.

j. Do not store combustibles on the stove top in employee break room.

k. Replace self closing mechanism on door to employee lounge.

l. Replace all missing/damaged ceiling tiles in corridors.

m. Adjust closer on laundry room door.

n. Remove storage from corridors.

o. Remove storage from n front of exit doors at laundry room corridor.

p. Burned out exit sign in corridor at laundry room.

q. Replace ceiling tile in janitor’s room downstairs.

r. Adjust self-closers in boiler room and janitor room.

s. Maintain 30" clearance around electrical panels in maintenance room.

t. Do not block access to fire extinguishers.

BMFEA
Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

April 3, 2003

Larry Oshinsky, Administrator
Acacias Care Center
601 N. Mongomery Street
Ojai, California 93024

RE: Operation Guardians Inspection

Dear Mr. Oshinsky:

The Operation Guardians team conducted a surprise inspection of Acacias Care Center, in Ojai, on February 20, 2003. The team identified the following issues:

1. There was a moderate odor of urine throughout the facility when the team entered, which persisted in some areas during the inspection. CHAIRS IN LOBBY RECENTLY CLEANED, STAFF REMINDED TO CLOSE LINEN BARREL LIDS.
2. The team found expired drugs in the medication refrigerator at the nurses' station. Expired medication removed. New pharmacy consultant will also monitor
3. The medication administration records lack signatures for the nurses' initials. These should be done when they give the first medication. Licensed nurses were inserviced on documentation, new pharm. consultant will do med pass - nurse also
4. The nurses' notes lack proper complete descriptions for injuries and pressure sores, including full location, complete measurements, and proper color descriptions. They lacked proper descriptions of drainage, color, consistency, amount, and description of odor. all pressure sore documentation is in the book on separate Pressure Sore Record which includes all the above and is integrated in permanent record (SEE ATTACHED FORM)
5. Resident care plans did not fully reflect the needs of the resident. Care plans are being updated
6. Time of writing was not present on the nurses' weekly summaries. It also appeared that the day shift wrote all summaries. They should rotate the weekly summary writing between both shifts to properly document the activities of the resident. Notes are also repetitive and lack any depth. Licensed nurses were inserviced regarding Quality and depth needed on summaries. Both shifts do summaries
7. MDS forms are to be completed by multiple disciplines and people. Most of those reviewed had no signatures, a couple had one signature and one had two signatures. This is insufficient.
all mds have RN signature as well as MDS Coordinator. other staff will be more involved in process.

ADDITIONAL INFO #1:
STAFF WILL BE GIVEN OPPORTUNITY AT NEXT GENERAL STAFF MEETING TO GIVE INPUT ON CONTROL OF URINE ODOR.

NOTE: NEW PHARMACEUTICAL CONSULTANT HIRED 3/03.

8. The interdisciplinary team conference forms reviewed lack any notes. A date and patient name are insufficient documentation. The IDT notes are only used for unusual occurrences
9. Resident [redacted]. (02-67-04) needs updated lab work done.
PLEASE BE MORE SPECIFIC.
10. Residents complained about the electrical system, lights do not always work and the rooms are too dark.
MAINTENANCE TO SURVEY ALL ROOMS.
11. The hallway handrails are in need of sanding and refinishing to prevent skin tears on the fragile skin of the residents.
MAINTENANCE TO REFURBISH.
12. Most bed cranks were noted to have been left out which can injure anyone walking near the end of the bed.
TO BE REVIEWED WITH SAFETY COMMITTEE.
13. The light was burned out in the oxygen room, many storage closets, and many exit signs.
MAINTENANCE TO REPLACE done.
14. Ceiling tiles were missing in areas throughout the facility.
COMPLETED.
15. The door alarms to the exterior doors were turned off when the team arrived, and were still off at 8:30 a.m., defeating the purpose of having them.
ONLY DOOR TO BASEMENT CAN BE TURNED OFF.
16. The closet labeled "Oxygen Room" was empty. This could be a problem for registry personnel or new staff in an emergency.
NO REGISTRY STAFF USED. FACILITY USES CONCENTRATORS.
17. There was a loose handrail by the resident dining room.
CORRECTED.
18. There was trash and old equipment near the building outside the facility. This could be hazardous to wandering residents, and creating an unsightly atmosphere.
BEING STRAIGHTENED OUT BY MAINTENANCE
19. The front door to the facility did not close properly. There was also a lack of good weatherstripping. Both problems allow flies into the facility.
WHEN UNLOCKED DOOR WAS OPEN BUT [redacted]LOCKED, IT CLOSES PROPERLY
20. There is a refrigerator in the hallway, in a small alcove. The refrigerator contains multiple food items that could be hazardous to confused residents. The refrigerator is in an unsupervised area allowing such access to all residents and visitors.
REFRIG. HAS PADLOCKS, LOCKS REAPPLIED
21. The wastebasket in the nurses' station was overflowing with trash and the litter extended to the floor.
LARGE BIN TO HOLD ALL LITER WILL BE OBTAINED.
22. The closet floors in the hallway storage rooms were very dirty.
WILL BE CLEANED UP.
23. The oxygen tanks in the oxygen storage closet were not properly secured.
CONTRADICTS # 16 ABOVE.
24. A table on the patio was severely damaged and could cause injury to residents.
WILL REMOVE WATER WARPED TABLE.

WEEKLY SKIN CONDITION PROGRESS REPORT

Treatment Order: _____

_____

_____

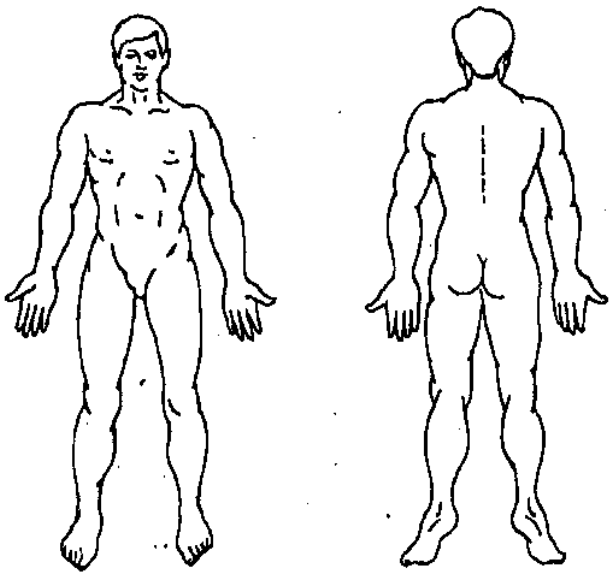
Date Identified: _____

Date Dr. Notified: _____

Cause: ☐ Diabetes ☐ Incontinence ☐ Paralysis

☐ Peripheral Vascular Disease

☐ Other _____



Identify multiple sites by either alpha or numeric characters.

Stage I: A persistent area of skin redness that does not disappear when pressure is relieved or does not blanch when pressure is applied.

Stage II: A partial thickness of skin is lost; may present as blistering surrounded by an area of redness and/or induration.

Stage III: A full thickness of skin is lost, exposing the subcutaneous tissues; presents as shallow crater; may be draining.

Stage IV: A full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone; the sore may be covered with an eschar, draining, necrotic, reddened, and/or indurated.

If not decubitus describe: _____

_____

_____

DATE	SITE	SIZE	DEPTH	PRESENCE/ ABSENCE DRAINAGE/TYPE	ODOR IF PRESENT	COLOR	STAGE	DESC. OF NECROTIC TISSUE	PHYSICIAN NOTIFIED DATE/TIME	NURSES TITLE/ SIGNATURE

NUTRITIONAL STATUS:
–Ideal Body Weight ..... ☐ At ☐ Above ☐ Below
–Appetite ..... ☐ Good ☐ Fair ☐ Poor

HYDRATION STATUS:
–Skin Turgor ..... ☐ Good ☐ Fair ☐ Poor
–Urine ..... ☐ Adequate ☐ Inadequate

PREVENTIVE MEASURES:
– Turned q_____hours
– Pressure Relieving Pads (type) _____

PROGRESS:
– Granulation ☐ Yes ☐ No – Decreased Depth ☐ Yes ☐ No
– Decreased Size ☐ Yes ☐ No – Decreased Drainage ☐ Yes ☐ No

NUTRITIONAL STATUS:
–Ideal Body Weight ..... ☐ At ☐ Above ☐ Below
–Appetite ..... ☐ Good ☐ Fair ☐ Poor

HYDRATION STATUS:
–Skin Turgor ..... ☐ Good ☐ Fair ☐ Poor
–Urine ..... ☐ Adequate ☐ Inadequate

PREVENTIVE MEASURES:
– Turned q_____hours
– Pressure Relieving Pads (type) _____

PROGRESS:
– Granulation ☐ Yes ☐ No – Decreased Depth ☐ Yes ☐ No
– Decreased Size ☐ Yes ☐ No – Decreased Drainage ☐ Yes ☐ No

NUTRITIONAL STATUS:
–Ideal Body Weight ..... ☐ At ☐ Above ☐ Below
–Appetite ..... ☐ Good ☐ Fair ☐ Poor

HYDRATION STATUS:
–Skin Turgor ..... ☐ Good ☐ Fair ☐ Poor
–Urine ..... ☐ Adequate ☐ Inadequate

PREVENTIVE MEASURES:
– Turned q_____hours
– Pressure Relieving Pads (type) _____

PROGRESS:
– Granulation ☐ Yes ☐ No – Decreased Depth ☐ Yes ☐ No
– Decreased Size ☐ Yes ☐ No – Decreased Drainage ☐ Yes ☐ No

NAME-Last	First	Middle	ROOM NO.	ATTENDING PHYSICIAN	CHART NO.

25. There were two tricycles, an improperly stored garden hose, BBQ lighter fluid and an unsecured gas BBQ at the back of the facility by a semi-attached building. These items were easily accessible to the residents and is a potential hazard to wandering residents.
SEMI-ATTACHED BLDG IS A PRIVATE RESIDENCE. - SEE BELOW -

26. A low fence with no lock surrounded the above items.
A LOCK WOULD BE A LIFE/SAFETY ISSUE W/F.D.

27. Dirty linen containers were not properly closed, allowing foul odors into the hallways.
REVIEWED W/STAFF.

28. The drinking fountain in the hallway was corroded and not working.
MAINTENANCE TO REMODE. H2O DISPENSER AT NURS. ST.

29. The washing machine in the laundry room was not working. The second machine was out of order and had been that way for a prolonged period.
SEE BELOW.

30. There was excessive lint built up in the back of the dryer, which could create a fire hazard.
CORRECTED. SCHEDULE TO BE POSTED.

31. There was a hole around the water meter that could be hazardous to residents wandering in the area.
TO BE CORRECTED BY MAINTENANCE.

32. There was excessive junk against the fence at the corner of Montgomery and Grand.
TO BE REMOVED BY MAINTENANCE.

33. There were rotting olives on the ground under the tress on the Grand Ave. side of the building.
ON GROUNDS OF PJT. RESIDENCE. WILL SEEK CLEANUP.

34. There were several bent and torn screens on the windows of the facility that would allow flies into the facilities when the windows are open.
TO BE REPAIRED BY MAINTENANCE.

35. There were multiple holes in the concrete that were formerly post holes, in the courtyard area, which would be hazardous to residents walking in the area.
TO BE REPAIRED BY MAINTENANCE.

36. There was an improperly stored garden hose left in the courtyard area that would be hazardous to anyone walking in the area.
MAINTENANCE STAFF INFORMED.

37. There were multiple fire code violations noted by the Fire Inspector, which they listed and left with the administrator by the inspector.
CORRECTED.

38. Staffing for January 11, 2003 was questionable. It appears that the licensed staff person left at approximately 5:00 p.m. and the oncoming nurse did not arrive for about two hours. This left the facility with no licensed staff person for a two-hour period. Staffing for that day only amounted to 2.6 hours per patient day. This is also well below the required level.
JAN 12TH 7A-7P LVN WAS NOT COUNTED.

39. Personnel files reviewed showed several problems:
    a. CNA [redacted] B[redacted]-missing TB testing documentation, physical examination states it is needed.
    b. LVN [redacted] has no medical file available; no TB testing and no physical exam documented.

ADDITIONAL INFO
35. ROOMS OPENING TO PATIO WILL HAVE "CHILD-PROOF" COVERS ADDED TO DOOR HANDLES.
29. WASHING MACHINE MAINTAINED BY INHOUSE + CONTRACT MAINTENANCE. FACILITY UTILIZES OUTSIDE LAUNDRY FOR SHEETS + PILLOWCASES. DISPOSABLE CHUX + DIAPERS USED IN INTER. 2ND MACHINE AWAITING FUNDING.

c. CNA [redacted] has no medical records available; no TB testing and no physical exam documented. She also has not been signed off on any policy or skills.
d. CNA [redacted] has no TB testing documented.
e. LVN [redacted] has no update on her annual physical exam since 3/31/01.
f. LVN [redacted] has no current license on file (expired 2/28/01), no TB testing in file at all, and the last annual physical exam was completed on 5/14/01.
g. RN [redacted] had conflicting TB results. A chest x-ray result in the file dated 2/3/99 indicates that she has a history of positive PPD tests (therefore should not had any further PPD tests). However, there is a recent PPD test in the file showing that the PPD is negative.

40. The residents' personal property inventory records were not up to date.

Please be advised that this is a summary of information available to us at this time. Should further information develop from the efforts of Operation Guardians, we will notify you at the appropriate time.

The Operation Guardians inspection completed does not preclude any Department of Health Services complaint or annual visits, any law enforcement investigation or other licensing agency investigation or inspection, which may occur in the future. It also does not preclude any further Operation Guardians unannounced inspection.

Although it is not required that you submit a plan of correction regarding the findings of the Operation Guardians inspection, please feel free to comment on the inspection and findings. Please send any comments to Special Agent Diana Boutin, 2025 Gateway Place, Suite 300, San Jose, California 95110. She may be reached by telephone at (408) 452-7366.

Sincerely,

Larry Menard

Larry Menard
Special Agent Supervisor
Bureau of Medi-Cal Fraud and Elder Abuse
Operation Guardians

For BILL LOCKYER
Attorney General

39. PPD TESTING RESUMED & PHYSICIAN WAS IN & STARTED ANNUAL PHYSICALS.
40. RNA TO QUARTERLY SURVEY COMPLETENESS OF INVENTORY RECORDS.

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
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1425 River Park Drive
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INSPECTION REPORT SUMMARY #142

Rick Isaacs, Administrator
Grove Street Extended Care & Living Center
1477 Grove Street
San Francisco, California 94117

Number of beds: 168

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Grove Street Extended Care & Living Center, in San Francisco, on March 4, 2003. The team identified the following issues:

Care Issues

1. All residents' room doors were closed creating an atmosphere of isolation and making wheelchair entry and exit very difficult for the resident without assistance. In talking with the San Francisco fire department, it appears that keeping the doors closed was not your only option. I would strongly encourage you to look into that option.

2. Residents' rooms were generally dark, cluttered, and musty smelling.

3. We noted a medicine cup of pills on the overbed table in room 205A ([redacted]B. 02-68-04), containing the medication from the night before. The medication administration record showed that they had administered the medication to the resident. Self-administration by this resident was not care planned nor was the resident assessed for such administration.

4. The medical record of [redacted]V. (02-68-01) contains an order for Donnatal PRN without a reason documented in the order.

5. The medical record of [redacted] H. (02-68-02) has an order to monitor the resident for side effects of Risperdal when the resident is no longer receiving the drug. This

order was carried over on the physician's order and should have been discontinued with the Risperdal.

6. The medical record of [redacted] S. (02-68-03) shows that the resident refuses to eat breakfast, but the CNA's are charting that he eats 80 to 100% of his breakfast.

7. Most of the medical records reviewed are in need of updated interdisciplinary team review.

8. Dr. S[redacted] does not date his signature on his physician's orders.

9. Physicians' orders are not documented as noted by the licensed staff, with the signature of the nurse, the date and time.

10. The weekly nurses' notes lack meaningful and informative narration.

11. The medication administration records for the current month lack signatures for the nurses' initials. They should sign them when the nurse gives the first medication.

12. Minimum Data Forms contain multiple signatures, but they have dated all the same, rather than the date the individual actually reassessed the line items.

13. Most of the care plans reviewed lack updated input. They were merely given a new review date.

14. One nurse is signing the nurses' notes with her initials only, rather than an appropriate signature (JB-RN).

Environmental

15. Some window screens were found torn.

16. Shower room doors had occupancy signs, but staff was failing to properly utilize them.

17. There was food in the nurses' station refrigerator on the 3rd floor which contained unlabeled food. The food was also in the refrigerator so that the door did not properly close.

18. In the kitchen walk-in refrigerator and the walk-in freezer, there was improperly covered and labeled food.

19. There was water damage noted to several walls.

20. There was damage noted to the ceiling tiles in several areas of the facility.

21. There was a broken window pane noted in the San Francisco Room.

22. There was carpet damage in the medical records room that could be a tripping hazard to staff in the room.

23. The door and screen were both open on the 2nd floor to the patio across from the nurses' station that allows insects into the facility.

24. There was a badly leaking faucet in the shower room near room 224.

25. There was dirty linen left on the floor in the shower room by room 224.

26. All housekeeping and janitorial closets were found unlocked and contained cleaning chemicals that could be extremely hazardous to confused residents.

27. The ice machine on the 2nd floor was leaking.

28. There was no separating shower curtain between the shower stalls in the 2nd floor men's shower room.

29. There was mildew beginning in several shower room stalls.

30. There was feces on the floor and a loose drain cover in the 3rd floor women's shower room.

31. The fan cover in the 3rd floor women's shower room was extremely dirty.

32. There was tile damage and dirt build-ups in the shower stall corners in the 3rd floor men's shower room.

33. There was considerable wall damage, including a hole, in the laundry room.

Administrative

34. The personnel file of LVN [redacted] D. showed that he has a positive PPD, with a 20 mm induration, but continues to work and pass medications without having been given a chest x-ray to rule out TB.

Staffing

We randomly reviewed staffing levels for four days. Four of the four days reviewed were below the minimum required hours per patient day.

Fire

a. Remove all storage placed in or near exits.

b. Provide five year certification of sprinkler and standpipe system.
c. Provide weekly training on evacuation procedures while construction project takes place.

d. Remove storage from furnace room.

e. Fire doors accessing exit corridors shall be kept closed or provide magnetic hold open devices.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
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and Elder Abuse
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95815-4524

Information: (916) 263-3896
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INSPECTION REPORT SUMMARY #143

Almaroof Apatira, Administrator
Victorian Healthcare Center
2121 Pine Street
San Francisco, California 94115

Number of beds: 90

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On March 5, 2003, the Operation Guardians team conducted a surprise inspection of Victorian Healthcare Center, in San Francisco. The team identified the following issues:

Care Issues

1. No one has documented the February physician's orders for resident [redacted] F. (02-69-02. The physician's order for Niacin 750 mg BID lacked a mode of administration. The PRN order for Tums lacked a reason for administration.

2. The medical record for resident [redacted] L. (02-69-03) documents a history of positive PPD., but lacked a chest x-ray or other follow-up in the file.

3. Overall the medical records lacked proper noting of the physicians' orders with the nurse's signature, and the date and time of the noting.

4. The medication administration records and treatment records lacked signatures for all the nurses' initials. This should be done the first time each nurse gives the medications.

5. Nurses' notes, although well documented, lacked the time of writing.

Environmental

6. There was a moderate odor of urine and feces throughout the facility when the team entered. This could be a result of the improperly covered dirty linen containers that were left overflowing with soiled linen.

7. There was uncovered and unlabeled food left on the counter of the station one medicine room, which the charge nurse said belonged to a resident.

8. There were several used toothbrushes found in shower room four, including one on the floor.

9. There were feces on the shower stall floor in shower room four.

10. There was soiled linen left on the floor in shower one.

11. There was mildew beginning in the corners of shower room one.

12. The screens on the sliding patio doors do not slide properly. The tracks need cleaning.

13. There are several screens on both windows and sliding doors that are very old and are torn and bent. This allows insects into the facility.

14. The hopper room hopper has a leaking faucet.

15. Although hallways had everything to one side when the team entered, by 9:00 a.m., wheelchairs, carts, and patients were lined up on both sides, blocking a clear exit pathway down the halls.

16. There was a ladder stored on the front patio propped against the wall. This is a potential hazard to residents in the area and they should store it in a more appropriate area.

17. There is a leaking washing machine in the laundry room, causing a large amount of water to leak onto the floor, which creates a hazard to staff.

18. There were several items in the kitchen refrigerator that they did not label.

Administrative

19. There were several 24-hour log books in a closet near the station two nurses' station. These contained specific patient information and should be stored in a locked area.

20. There were several fire violations, as noted by the City Fire Inspector, which they listed and left with the administrator.
21. There were several personnel files reviewed which lacked up to date TB testing and

annual physical exams.

22. Several residents have televisions sets that they have listed on their inventory records in the medical record. The individual television sets are not properly labeled with the residents' names and the team suggests listing the serial numbers on their inventory record along with the brand and TV size.

Staffing

No problems were detected

Fire

a. Remove obstructions to exit doors and unit pathways on east emergency exit, first floor and east exit in basement.

b. No records that the Fire alarm is being certified annually and that records of maintenance are being kept.

c. Remove storage from generator area.

d. Maintain corridors free of obstructions by keeping items on one side of the hall.

e. Repair fire doors so they properly latch in the education center, business office, and living center.

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State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
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INSPECTION REPORT SUMMARY #144

Francis Shey, Administrator
Manorcare Health Services
944 Regel Road
Encinitas, California 92024

Number of beds: 120

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Manorcare Health Services, in Encinitas, on March 11, 2003. The team identified the following issues:

Care Issues

1. There was a mild to moderate odor of urine throughout the facility when the team entered.

2. The current medication administration records lacked signatures for all the nurses' initials. These should be done when they give the first medication.

3. The nurses' notes lacked proper complete descriptions for injuries, and pressure sores including full location, complete measurements, and proper color descriptions. They also lacked proper descriptions of drainage, color, consistency, amount, and a description of an odor.

4. The medication administration record does not reflect the results of PRN medications that they gave.

5. Licensed staff had not noted some physicians' orders.

6. Dr. S. did not sign physicians' orders monthly, although he has written monthly progress notes.

7. All MDS assessments were not done in a timely manner.

8. The station one medication room door was unlocked and unattended.

Environmental

9. The central supply room, which contained syringes and other potentially hazardous supplies, was unlocked and unattended.

10. The treatment cart was left in the station two hallway unlocked and unattended, and contained multiple medicated ointments.

11. There was a used, unlabeled toothbrush left in shower room seven.

12. There were smeared feces on the floor of shower room seven.

13. The oxygen closet was extremely messy and disorganized.

14. The light was burned out in shower room nine.

15. There was a badly damaged door in the laundry room.

16. The exterior door in the kitchen will not open from the inside without a key, which was not readily accessible and could be a problem in a fire.

17. The Alzheimer unit activity storage closet was unlocked and contained potentially hazardous items easily accessible to confused residents. The closet also contains the electrical panel for the unit which was left accessible to the residents.

18. There was moderate stucco damage to the exterior wall of the facility on the smoking patio. There was a large quantity of an unknown foamy substance sticking to the damage.

19. There was soil erosion tunneling under the concrete on the smoking patio.

20. There was a displaced drain cover on the smoking patio.

21. There were multiple wasp nests found under the eaves of the facility, including the patios.

22. There was food in the walk-in refrigerator that they covered, but did not properly label and date.

23. There was water puddled in the ice machine room of the Alzheimer's unit.

24. Shower room one on the Alzheimer's unit smelled bad, and the shower control knob cover was damaged.

25. Shower room three on the Alzheimer's unit had a damaged drain cover and dirty, wet linen on the floor.

26. The soiled linen room on the Alzheimer's unit was unlocked and contained an overfilled sharps container full of used razors.

27. There were multiple, slightly bent, screens on the windows. They were bent sufficiently to allow flies into the facility if the windows were open.

28. There was a broken window in the back of the facility.

Administrative

29. There were multiple fire code issues discovered by the Encinitas City Fire Inspector that they listed and left with you.

30. You are not surrendering trust fund accounts in a timely manner following the death of a resident.

31. There was co-mingling of trust funds and facility funds noted.

Staffing

No problems were detected

Fire

No problems were detected

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INSPECTION REPORT SUMMARY #145

Siegmund Diener, Administrator
Brighton Place-La Mesa
7760 Parkway Drive
La Mesa, California 91942

Number of beds: 60

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Brighton Place-La Mesa, in La Mesa, on March 12, 2003. The team identified the following issues:

Care Issues

No problems were detected.

Environmental

1. Some handrails need refinishing.

2. The light is missing in the utility room by room four.

3. There were snack and soda vending machines on the residents' patio. These could be a potential hazard if you give the residents on special diets unsupervised access to the machines.

4. The bath tub in the bathing room across from the nurses' station was dirty.

5. Some bed cranks were left out under the beds of the residents and could be hazardous to someone walking near the foot of the beds.

6. There was a soiled washcloth left on the floor of the shower room across from room eight.

7. There was a sharps container sitting on the floor of the shower room across from room eight. The lid to the container was not in place and they could easily reach the used razors from the top.

8. The front entrance door is in need of weatherstripping to prevent insects from reaching the interior of the facility.

9. There was an active wasp nest found under the eaves on the side of the building.

10. There was a hole in the stucco under the eaves on the side of the building.

Administrative

No problems were detected

Staffing

No problems were detected

Fire

Unavailable

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INSPECTION REPORT SUMMARY #146

Jason Bliss, Administrator
Cottonwood Healthcare Center
625 Cottonwood Street
Woodland, California 95695

Number of beds: 98

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On March 18, 2003, the Operation Guardians team conducted a surprise inspection of Cottonwood Healthcare Center, located in Woodland,. The team identified the following issues:

Care Issues

1. There was a moderate offensive odor throughout the facility. The odor of ammonia was especially strong in the formal diningroom.

2. We observed staff being slow to answer call lights. We observed licensed staff passing by rooms without stopping to ask what the resident needed.

3. The Minimum Data Sets did not match the residents' condition as recorded in the nurses' notes.

4. The licensed staff failed to note the time when noting physicians' orders.

5. The licensed staff is not always noting doctors' orders.

6. Nurses' notes lacked descriptions and measurements of wounds and injuries, including bruising, with exact location of injury. There notes also lacked follow up descriptions on later entry dates.

7. Weekly nurses' notes are not present regularly.

8. Dr. K. is not visiting residents regularly.

9. Initial evaluations are not being done within the required 72 hours of admission.

10. Staff has not properly filled out vital signs and weight records at the top with the height, admission weight, dates of birth, etc., although space is allotted for the information.

11. The medication administration records lacked signatures for many nurses' initials.

12. Our medical record review of [redacted] P. (02-72-01) showed physicians' orders signed 2/24/03, but not properly noted by licensed staff. The January physician's orders were signed by the doctor on March 7, 2003 and not noted by licensed staff. The doctor ordered Aricept and Zyprexa to be given ever night in February, but are not initialed as given every night and there is no reason documented for withholding them.

13. The medical record of [redacted] K. (02-72-02) showed physicians' orders signed 3/5/03, but were not noted by licensed staff. February orders were also not noted. Also blood sugars were not checked although it is care planned that the patient is at risk for post prandial falls.

14. The medical record of [redacted] O. (02-72-04) did not have a Minimum Data Set in the record when reviewed.

15. The medical record of [redacted] A. (02-72-07) had an admission note by the physician. However, the physician had not signed it. The physician's orders are not noted by licensed staff for 9/02, 10/02 and 1/03.

16. The medical record of [redacted] W. (02-72-08) showed a diagnosis of Hepatitis C, but no one has addressed this issue and necessary precautions in the care plan.

17. The medical record of [redacted] L. (02-72-10) showed a diagnosis of Hepatitis C, but no one addressed this issue in the care plan.

Environmental

18. There was a lawn mower and tree trimming equipment left out on the front patio that could be a potential hazard to confused residents.

19. There were TV cables hanging from the roof across walkways on the patio causing a hazard.

20. Bed cranks were not properly stored under the foot of the residents beds, causing a potential hazard to anyone walking at the foot of the bed.

21. There was an extension cord used in room 138C.
22. There were dirty linen containers in the station two utility room that were not

properly covered causing a foul odor.

23. They corrode the faucet in the utility room hopper and leaking.

24. There was a used vinyl glove left on the ground outside the facility.

25. There are large areas of fence damage around the facility.

26. There is a substantial hole in the eave in the front of the facility.

27. There is an uncovered light bulb outside, which could create a potential hazard.

28. The large refrigerator in the kitchen needs a new gasket as condensation is forming outside the door.

29. The back screen to the kitchen door needs weatherstripping to prevent flies from entering the kitchen area.

30. The screen door in the laundry room does not close properly.

31. There are several bent screens that could allow flies into the facility when residents' windows are open.

Administrative

32. Residents' Rights are not posted in a prominent place.

33. The personnel file of RN [redacted] M[redacted]. lacked an up to date license. There was no TB testing and no physical exam in her file.

34. The personnel file of LVN [redacted] K. had no up to date TB testing or physical exam.

35. The personnel file of LVN [redacted] A. had no up to date license. There is no TB testing or physical exam in her file.

36. The personnel file of DON [redacted] F. had no physical exam documented.

37. The personnel file of CNA [redacted] D. had no documentation of a certification number or expiration date, no reference checks, and no elder abuse training documented.

38. The personnel file of CNA [redacted] C. had no certification number or expiration date, no references documented, and no TB testing or physical exam.

39. The personnel file of dietary supervisor [redacted] S. had no physical exam documented.

Staffing

Below minimum daily requirements.

Fire

a. Provide service to hood system in kitchen.

b. Submit plans for alterations to hood system due to new appliance ordered.

c. Provide service to fire extinguisher.

Cottonwood Healthcare Center

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Diana Boutin, R.N.
Special Agent—Operation Guardians
2025 Gateway Place, Ste. 474
San Jose, Ca 95110-1006

04-18-03

To follow you will find what Cottonwood Healthcare Center is doing to remedy the areas observed by your recent visit. We appreciate the opportunity to grow and make this place a better living environment.

1. Odor is being eliminated through round checks by DNS, Nursing Supervisor, Charge Nurses, Aides, & Department Managers on more routine basis. In addition, soiled-linen barrels are emptied more routinely by Environmental Department.

2. Call Light study implemented by all Department Managers; results shared with Administrator and DNS in daily stand-up meetings.

3. MDS' and nurses' notes audited by Nursing/Medical Records to ensure accuracy.

4. Licensed Staff inserviced by DNS for compliance. Medical Records audit daily for compliance with results given to DNS for correction.

5. Licensed Staff inserviced by DNS for compliance.

6. Licensed Staff was inserviced by wound care consultant and DNS. Medical Records audit daily for compliance with results given to DNS for correction.

7. Licensed Staff inserviced by DNS for compliance. Audits done by Medical Records daily for compliance with results given to DNS for correction.

8. Dr. K[redacted] and other physicians contacted via letter informing them of visit mandates on 03-20-03

9. Physicians contacted via letter informing them of visit mandates on 03-20-03.

10. Staff inserviced by DNS/Staff Developer for compliance. Nursing Supervisor/DNS audit 24hrs and correct as needed.

11. Licensed Staff inserviced by DNS for compliance. Medical Records to audit 2x a week with results given to DNS for correction.

12. Orders have been noted late, but carried out.

13. The physician's orders have been noted. DNS gave one-on-one inservice to Licensed nurses on noting physicians orders. The resident's plan of care was updated to include checking the blood sugar prn.

14. MDS' now in chart.

15. The attending physicians have now signed the admit note and the physician's orders have been noted.

16. Care plans have been updated to reflect changes.

17. Care plans have been updated to reflect changes.

18. Both lawn mower and tree trimming equipment removed.

19. TV cables securely fastened.

20. Staff Inserviced on bed crank usage, and rounds done daily for compliance.

21. Extension cords replaced with three-prong wire adapters.

22. Linen containers properly fitted and maintained through routine round checks.

23. Hopper fixed.

24. The facility improvement manager rounds by section to include monitoring of outside grounds. The staff will be inserviced on proper glove disposal by the DNS/DSD.

25. Fence repaired.

26. Hole fixed.

27. Light-bulb covered.

28. Refrigerator repaired.

29. Back screen door in kitchen weather-stripped properly.

30. Screen door in laundry fixed.

31. Bent screens fixed throughout facility.

32. Resident Rights posted in prominent location.

33–39.—Audit already completed, all references & license verifications–100%. TBs and Physicals being conducted weekly—70% completed as of 04-13-03.

40. Inventory record usage reviewed with staff, and labeling of personal property discussed for compliance.

Once again, thank you for your assistance.

Sincerely,

Jason Paul Bliss
Administrator

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State of California Department of Justice

Office of Attorney General
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INSPECTION REPORT SUMMARY #147

David Yarbrough, Administrator
Walnut Whitney Convalescent Hospital
3529 Walnut Avenue
Carmichael, California 95608

Number of beds: 126

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Walnut Whitney Convalescent Hospital, located in Carmichael, on March 19, 2003. The team identified the following issues:

Care Issues

1. There was a moderate odor throughout the facility noted by the team.

2. A review of the medical records showed that the physicians' orders are not properly noted by the licensed staff by documenting the date, time and signature of the nurse noting the order.

3. The medication administration records lacked many signatures for the nurses' initials. This should be done when they give the first medication.

4. Review of the medication administration records revealed that many PRN medications given lacked documentation of the results of the medication given.

5. The Minimum Data Sheets and Nursing Care Plans do not match the documentation found in the nurses' notes for those medical records reviewed.

6. The nurses' notes lack complete descriptions of incisions, wounds, and injuries. This includes a lack of sufficient location and size description.

7. The progress notes written by Dr. S. lacked physical findings necessary to show they performed a physical exam.

8. We noted that Dr. [redacted] M. was not making monthly visits to his patients.

9. The medical record of resident [redacted] T (02-73-01) showed that the doctor's orders signed by the physician on 3/4/03 were not noted by licensed staff. There is no physician progress note for February in the record and no physical findings in the March progress note.

10. The medical record of [redacted] S (02-73-05) has an order for Tylenol 500 mg. 2 tabs (650 mg) P.O. t.i.d.. Two 500 mg tablets would equal 1000 mg, and Tylenol 500 mg are actually Tylenol ES tablets. They have carried over the order for several months without correction.

11. The medical record of [redacted] S (02-73-07) lacked an annual history and physical exam for 2002 and had no physician's signature on the orders for 12/02, 1/03 or 2/03.

12. The team noted that there were only two staff in the dining room feeding 15 residents, allowing the residents food to get cold while they were waiting to be fed. There also was no verbal or visual stimulation during the meal.

13. Residents complained that food is frequently cold when they serve it to them although they bring it out of the kitchen hot. The team observed this and previously made mention in this letter to the lack of staff to serve meals.

14. The residents complained that staff are slow to answer call lights. The team, several times, observed licensed staff passing by rooms in which residents had activated the call lights.

Environmental

15. There were gardening equipment and hoses on the patio, which they improperly stored, creating potential walking hazards to the residents.

16. The bed cranks for the residents' beds were not properly stored and create a hazard to anyone walking near the foot of the bed.

17. There was floor-to-wall coving missing in multiple areas of the facility.

18. The utility room on station one was unlocked and unattended, and there were chemicals left out.

19. There were several wheelchairs with badly cracked armrests.

20. There was uncovered and improperly labeled food in the walk-in refrigerator in the kitchen.

21. There was mildew in the corners of the shower rooms.

22. There was water damage to the wall in the shower room on station two.

23. The sharps container in the utility room on station two was overflowing and the door to the utility room was unlocked, creating a potential hazard to confused residents.

24. There was soiled, and very foul smelling linen left on the top of the soiled linen container in the station two utility room.

25. There was a wasp nest under the eave in the front of the facility.

26. There were multiple bent, torn and off-track window screens around the facility.

27. The screen on the exterior door in the kitchen was missing and the door was left open.

28. The sliding door screens do not slide properly and need to be cleaned.

29. Oxygen tanks being stored outside were not properly secured and create a potential hazard.

30. The window screen in the laundry room was badly off-track allowing flies into the room and potentially contaminating clean linen.

Administrative

31. The personnel file of LVN [redacted] E. lacked an up to date license verification on file with a current expiration date.

32. The personnel file of CNA [redacted] H. lacked documentation of TB testing and a physical exam.

33. The personnel file of RN [redacted] L. lacked documentation of TB testing and a physical exam. There was also no documentation of reference checks.

34. The personnel file of LVN [redacted] L. lacked documentation of TB testing and a physical exam. There was also no documentation of reference checks.

35. The personnel file of LVN [redacted] A. lacked documentation of TB testing and a physical exam. There is also no documentation of reference checks.

36. The personnel file of RN [redacted] L. lacked documentation of TB testing.

37. Overall the personnel files lacked documentation of reference checks and criminal background checks.

38. The residents' personal property inventory records were not up to date and they did not label personal property.

Staffing

Staffing levels were below the minimum hours per patient day required by regulation for three of the four days reviewed.

Fire

Unavailable.

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INSPECTION REPORT SUMMARY #148

Eric Bultez, Administrator
Sherwood Healthcare Center
4700 Elvas Avenue
Sacramento, California 95819

Number of beds: 62

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a revisit inspection of Sherwood Healthcare Center, located in Sacramento, on March 20, 2003. The team identified the following issues:

Care Issues

1. There was a moderate odor throughout the facility noted by the team.

2. A review of the medical records showed that the physicians' orders are not being noted by the licensed staff by documenting the date, time, and signature of the nurse noting the order.

3. Admission notes in the medical records lacked adequate descriptions of the residents' physical and mental condition.

4. Review of the medication administration records revealed that many of the prn medications given lack documentation of the results of the medication given.

5. The Minimum Data Sheets and Nursing Care Plans do not match the documentation found in the nurses' notes for those medical records reviewed.

6. Wounds described in the nurses' notes lacked completeness and proper descriptions as well as location, size and description.

7. The medical record of resident [redacted] D. (02-74-02) gives conflicting descriptions. In one instance, staff described the leg wound as old with no previous description. A few hours later staff described the wound as new.

8. In general, the residents complained that staff were slow in answering call lights at night and were unnecessarily noisy.

Environmental

9. There was food found in the medication refrigerator next to medication.

10. There was open food belonging to the staff nurse in the medication room.

11. There was a used glove found on the floor in room 11.

12. Access to the oxygen tanks in the utility room was blocked by multiple soiled linen containers.

13. There was tile damage in the shower room by room 14.

14. There was soiled linen left in the shower room across from the kitchen.

15. There was an unsecured oxygen tank in the utility room across from the office of the Director of Nurses.

16. There were large numbers of broken down cardboard boxes piled next to a flammable storage unit outside.

17. There was a torn sliding door screen on the south side of the building.

Administrative

18. The personnel file of LVN [redacted] B. lacked TB testing and a physical exam on file. There was also no documentation of references being checked or a criminal background check.

19. The personnel file of dietary supervisor [redacted] A. lacked documentation of TB testing and a physical exam in the file. There was also no refererence checks documented.

20. The personnel file of CNA [redacted] A. lacked documentation of TB testing and a physical exam.

21. The personnel file of [redacted] R. lacked documentation of TB testing and a physical exam. Her file also lacked any reference check or criminal check documented.

22. The personnel file of CNA [redacted] C. lacked documentation of a reference check

or criminal check.

Staffing

Staffing levels were below the minimum hours per patient day required by regulation for three of the four days reviewed.

Fire

Not applicable

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INSPECTION REPORT SUMMARY #149

Mark Towns, Administrator
Clearview Convalescent Center
15823 S. Western Avenue
Gardena, California 90247

Number of beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise inspection of Clearview Convalescent Center, located in Gardena, on March 25, 2003. The team identified the following issues:

Care Issues

1. Some items in the medical records were out of order. For example, lab work was found in the doctors' orders section, and assessments in the medications section.

2. The medical record of [redacted] V (02-75-01) had a recommendation made by the dietary supervisor written on 3/13/03 that was not transmitted to the doctor until 3/17/03.

3. The medical record of [redacted] W. (02-75-03) had a physician's verbal order taken on 1/03/03 which has not been signed by the physician.

4. The medical record of [redacted] M. (02-75-07) is missing the initial history and physical.

Environmental

5. Some exterior doors lacked sufficient weatherstripping to keep out flying insects.

6. There was some undated food in the kitchen refrigerator.

Administrative

7. Many staff were not wearing identifying name tags when the team entered the facility at 7 a.m.

8. In general the personnel files lacked documentation of reference checks and criminal background checks.

9. There is no physical exam in the personnel file of RN [redacted] L.

10. There is no TB testing documented in the personnel file of DON [redacted] H.

11. There is no TB testing documented in the personnel file of CNA [redacted] A.

12. There is no TB testing documented in the personnel file of dietary supervisory [redacted] A.

Staffing

No problems were detected

Fire

No problems were detected

clearview
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15823 south western avenue / gardena, california 90247-3788 / (310) 538-2323 / (323) 770-3131 / fax (310) 538-3509

Special Agent Diana Boutin
Office of the Attorney General
Bureau of Medi-Cal Fraud & Elder Abuse
2025 Gateway Place, Suite 300
San Jose, CA 95110-1006

April 15, 2003

RE: Operations Guardians Inspection

Dear Ms. Boutin

In response to your Operation Guardians Inspection at Clear View Convalescent Center on 25 March 2003, we wish to advise you of the erroneous conclusions you made. Following are each item you identified as problems.

1. We admit some our employees can't remember to bring their name-tag to wear from home. Others wear the tag on their uniforms, but in cold weather, place a sweater or coat on over the name tag, not realizing it cant be read unless on their outer clothing. Some wear it on a key cord placed around their necks. And some wear ir on their waist. Trying to get 158 full time employees to always place the tag in a readable position is a constant problem I have faced here for 48 years, 3 months and 1 day. I have not been successful, but we'll keep at it. By the way, your team showed up without identification cards or badges. They were refused admission, and had to go back to their cars and get their proper ID before we would allow them to enter. Now I realize why we were zinged on this issue.

2. Your inspectors should have realized that the lab work was placed, temporarily, in the physician's order section of the chart to make sure the doctor actually saw the lab report, initialed it to verify he or she had seen it, and was not a result of careless charting. Frequently, when items need to be verified as having been seen by the doctor are just placed in the lab section, the doctor doesn't want to waste time searching through the chart, and omissions have occurred. Once the doctor initials the form, they are correctly placed in the proper area of the chart. If you had asked us, we could have told you this is a simple way to prevent errors. And, I believe, this is a standard way of adhering to proper protocols throughout the medical industry. You drew the conclusion we don't know how to file. You are

wrong. Trying to get doctors to remember that they ordered lab work and sign their acknowledgement of the results is almost impossible. Our professional medical records personnel use the above technique to make sure everything is properly noted. We are not sloppy people, and you should have asked us if you are not familiar with different procedures. We have signs posted throughout the facility saying 'IF YOU DON'T ASK, YOU WON'T KNOW. IF YOU DON'T KNOW, ASK." Maybe you should post some of these signs for your staff.

3. This is a correct flaw in our system. The Los Angeles County Health Department zinged us year before last with a deficiency because a change order from non-fat milk to skimmed milk was not performed until the following morning. This observation of yours resulted in my telling the dietician not to come late in the day, after the DON has gone home, on a Thursday or Friday, when the attending physician would not be here until the following Monday. Any item done by the Dietician is a recommendation. Not an order. If it is serious, such as a person having been diagnosed as diabetic, and to withhold sugars, the attending physician is called immediately with the recommendation. If the order is "give 2 slices of toast instead of 1", we haven't really worried about the speed. The next day would probably be okay. We make sure that if the recommendation is really important, the RN is notified directly by the Dietician, in person, to effectuate the recommendation, if the physician so desires. Not all recommendations are utilized, as some are just put in the Dieticians report to verify they have reviewed the patient's file, and to justify their hours of service. We'll try to do better in the future.

4. This is why we prefer to have certain doctors work here, rather than others. Some physicians, especially those from Kaiser, will not come in to sign telephone orders they have given us. A problem we have right now is that the doctor from Kaiser stopped coming here, and he didn't sign his verbal and telephone orders. When his replacement came in, she refused to sign the previous orders. We have contacted Kaiser regarding the problem, and "they are looking into it." Title 22 requires us to have the doctor's sign a verbal or telephone order within 72 hours. This is not always possible, because, as you probably know, some doctors are impossible to work with. Even mailing them a form to sign does not always get the form returned to us within 72 hours. One Kaiser doctor said, "he only signs forms on Fridays". Well, what can we do? Our Medical Director usually signs another doctor's order, if the doctor can't get in, or has to make a special trip just to sign his or her name. But there are orders for prescription drugs he will not sign. I guess we just get in the car, wait in the doctor's waiting room, get the signature, and return it to the chart. Right? I can't wait until our software company develops electronic signature procedures for us to use. We can't find a software company that has affordable programs yet, but we are continuing to look.

5. The "missing" history and physical was in the Admission records. We would have shown it to you had you told us you thought it was missing. (Copy attached)

6. I am unaware of any flying insects coming into the building because of insufficient weather-stripping. We have never had a problem in this area, nor has anyone indicated previously that this could be a problem. This building was opened in December of 1965. No flying insects noted since then. But, we'll take a look at the "potential" problems of the future.

7. We are not going to change the procedure for this "identification of issue". Fruit juice was removed to the kitchen and poured into individual glasses, with plastic wrap placed over the top of each of 170 plus glasses. The glasses, filled with juice, were put on trays and placed in the refrigerator (we call it the walk-in box) for keeping until they were placed on the individual tray of each patient. The trays were stacked on top of each other, with the top tray labeled. The tray was labeled, but we don't label each glass. They were in the walk-in box approximately 3 hours. As the individual resident trays were set-up, a glass of juice, according to favorites determined by the resident, was removed from the trays cooled in the walk-in box and placed on the residents individual tray. There were three kinds of juice served that morning: orange juice, prune juice and tomato juice. Evidently, the top tray in the walk-in box, stacked one on top of the other, was the only one dated, and it had been removed to the kitchen for set up on the trays, leaving the others "undated". The entire procedure of completing the individual trays takes about 35 minutes. You find this as "undated"? Do you really think we should have dated the glasses, or isn't dating the trays of glasses sufficient? Do you think we would forget that we poured about 170 glasses, and not use them? Do you think we may pour a week's worth of juice, and then can't figure out which juice is to be served on some far date? Come on. This is a flimsy item and you shouldn't have included it.

8. All employees have reference checks. The one on [redacted] RN was one that was misfiled, and was with her physical exam record. We could have provided it if you had told us what you were looking for. (See item 9). I am unaware that criminal background checks are required of applicants. Would you see that I am provided with the appropriate section of the law that requires this? I will then be able to comply with that law (if there is one.) Since all Licensed Registered Nurses and Licensed Vocational Nurses, and Certified Nursing Assistants have criminal checks by the State of California, (at the renewal of their license or certification) we only do checks on those rare individuals who commit a crime (like a fraudulent Worker's Comp case or one where we are notified by law enforcement that there is an issue at hand). This has only happened a few times in my almost 50 years as Administrator or Licensee.

9. The law requires us to keep medical information separate from regular personnel records. Since you didn't tell us what you were looking for, we couldn't provide it to you. A copy of the reference check and physical exam on [redacted], RN are attached,

10. Refer to my response in 9 above. TB testing of [redacted] RN is attached.

11. Refer to response in 9 above. TB testing for [redacted] CNA is attached.

12. Refer to response in 9 above. TB testing for [redacted] DSD is attached. (The lab misspelled his name, so we are enclosing his application to verify his date of birth, as shown on the lab sheet).

Please check and correct your records. Clear View has been rated in the top 1% (one out of 260) of nursing homes in the United States by the Joint Commission on Accreditation of Health Care Organizations, and we are told, in the top 10 in California. Your poor survey would indicate that we don't know how to file, don't bother to check on the references of applicants, don't check them for TB, don't date food in the refrigerator, don't keep flying insects out, don't get doctors to sign for their orders, etc. You are wrong on all but three items, all of a non-consequational basis. We'll continue trying to do our best (as we are the best), but teams will always find an undotted i or an uncrossed t somewhere to find fault with us. We're used to it...

Thank you,

CLEAR VIEW SANITARIUM, INC.

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President

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INSPECTION REPORT SUMMARY #150

Michael Kerr, Administrator
Memorial Hospital of Gardena D/P SNF
1145 W. Redondo Beach
Gardena, California 90247

Number of beds: 69

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

On March 26, 2003, the Operation Guardians team conducted a surprise inspection of Memorial Hospital of Gardena D/P SNF, in Gardena. The team identified the following issues:

Care Issues

1. The treatment cart had been left unlocked and unattended in the hallway, and contained medicated ointments.

Environmental

No problems were detected

Administrative

2. The required posting of the daily staffing had not been changed since Monday March 24.

Staffing

No problems were detected

Fire

No problems were detected